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CATASTROPHIC HEALTH INSURANCE

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

FIRST SESSION

MARCH 19, 1987

Printed for the use of the Committee on Finance

Part 2 of 3

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CATASTROPHIC HEALTH INSURANCE

THURSDAY, MARCH 19, 1987

U.S. Senate,
Committee on Finance,
Washington, DC.

The hearing was convened, pursuant to recess, at 10:10 a.m. in room SD-215, Dirksen Senate Office Building, Hon. Lloyd Bentsen (chairman) presiding.

Present: Senators Bentsen, Matsunaga, Baucus, Mitchell, Daschle, Packwood, Danforth, Chafee, Heinz, Wallop, and Durenberger.

[The press release announcing the hearing, the prepared written statements of Senators Mitchell and Heinz and a comparison by the Congressional Research Service follow:]

[Press release H-23, March 5, 1987]

Finance Committee to Hold Hearing on Catastrophic Health Insurance

Washington, DC.—Senator Lloyd Bentsen (D., Texas), Chairman, announced Thursday that the Finance Committee will hold a hearing to further consider the issue of catastrophic health insurance. This hearing will focus on the impact of catastrophic health insurance on consumers and health care providers, and the Committee hopes to hear testimony from representatives of these groups.

Chairman Bentsen stated that the President's proposal to provide catastrophic coverage for acute care expenses under the Medicare program has provided an important starting point for the debate over how best to provide financial protection against the expenses of a catastrophic illness. He further stated that the Committee will actively explore ways to improve access to services to ease the transition from hospital care for Medicare patients.

The hearing will begin at 10:00 a.m. on Thursday, March 19, 1987 in Room SD-215 of the Dirksen Senate Office Building.

OPENING STATEMENT

OF

SEN GEORGE J. MITCHELL

FINANCE COMMITTEE HEARING

ON

CATASTROPHIC HEALTH CARE COSTS

MARCH 19, 1987

The Congress is clearly concerned about the problems that are a result of high out of pocket expenses for health care. As I have noted in the past, this burden most often falls on individuals and their families at a time when they are trying to cope with serious illness or injury.

As we begin to consider what action may be desirable at the Federal level to address the problem, we must remain mindful of several important considerations. The first is that equity, both in benefits and financing must be carefully considered. Which groups are not recieving services that they truly need? What individuals or groups are currently paying more or less than an equitible share for the services that are currently utilized?

In many instances the problem is that those individuals that have the most severe chronic illnesses pay a far greater share of their expenses themselves than so those persons with acute illness. Is that fair or desirable?

A second consideration is that policies to address the problem of catastrophic illness must consider the important role of the family, both in the care delivered and in financing. One of the most pressing issues in this regard is current policy of literally forcing spouses of Medicaid nursing home patients into poverty.

Finally we must guard against creating false hope by pronouncements that a catastrophic health care proposal that is focused solely on acute care has eliminated the fear of catastrophic health care costs. Clearly this is a first, but very limited step in the right direction. We must move quickly but carefully to eliminate the fear and the reality of the inequitible and unnecessary burden of catastrophic costs from chronic illness.

STATEMENT BY
SENATOR JOHN HEINZ

COMMITTEE ON FINANCE
HEARING ON CATASTROPHIC HEALTH CARE COVERAGE
THURSDAY, MARCH 19, 1987

MR. CHAIRMAN, I COMMEND YOU FOR CALLING THIS HEARING SO THAT WE MAY HEAR TESTIMONY FROM THOSE GROUPS WITH A VITAL INTEREST IN THE ISSUE OF CATASTROPHIC HEALTH CARE COVERAGE.

IN RECENT WEEKS I HAVE BEEN IMPRESSED BY THE ENORMOUS PUBLIC INTEREST IN CATASTROPHIC HEALTH CARE. WE, OF COURSE, HAVE THE PRESIDENT AND SECRETARY BOWEN TO THANK FOR GETTING THE BALL ROLLING. WITH THEIR PROPOSAL NOW BEFORE US, AS WELL AS THOSE PREPARED BY SEN. DOLE AND REPS. STARK AND GRADISON, IT IS NOW OUR JOB TO PEEL OFF THE LAYERS OF HOPE AND EXPECTATION FROM THESE PROPOSALS AND TO EXAMINE CAREFULLY WHAT THEY COVER AND HOW THEY WILL BE FINANCED.

AS WE DISSECT THESE PROPOSALS I WOULD ASK THAT WE KEEP SEVERAL THINGS IN MIND. FIRST, DO THE PROPOSALS ADDRESS THE MOST CRITICAL CATASTROPHIC PROBLEMS FOR MOST OLDER AMERICANS? MY REVIEW OF THESE PROPOSALS SUGGESTS THAT THEY DO NOT. FOCUSED AS THEY ARE ON ACUTE CARE PROBLEMS, THE GREATEST CATASTROPHE -- LONG TERM, CHRONIC CARE, WHICH INFLICTS 5 OUT OF 6 OLDER PERSONS WHO SUFFER CATASTROPHIC HEALTH CARE EXPENSES -- IS LEFT UNCOVERED.

SECOND, DO THE PROPOSALS RELY ON SOUND FINCANCING MECHANISMS THAT DO NOT ADD TO THE FEDERAL DEFICIT AND DO NOT UNFAIRLY BURDEN THOSE LEAST ABLE TO PAY? THE THREE PROPOSALS BEFORE US DIFFER

DRAMATICALLY IN THEIR FINANCING, WITH TWO RELYING SOLELY ON PREMIUMS AND THE OTHER ON TAXATION OF THE IMPUTED VALUE OF MEDICARE. OTHER FINANCING PROPOSALS HAVE BEEN SUGGESTED, SUCH AS RAISING THE TOBACCO EXCISE TAX, INCLUDING STATE AND LOCAL EMPLOYEES IN THE MEDICARE PROGRAM AND ADDING A MEDICARE SURTAX FOR HIGHER INCOME ELDERLY TAXPAYERS. WE MUST SEEK THE BEST COMBINATION OF THE AVAILABLE FINANCING PROPOSALS TO ENSURE AN EQUITABLE DISTRIBUTION OF COSTS.

THIRD, DO THE BENEFITS OFFERED BY THE PROPOSAL JUSTIFY THE COST INCURRED TO BENEFICIARIES AND TAX PAYERS? A PROPOSAL THAT IS TOO MODEST OR TOO NARROWLY DEFINED MAY NOT JUSTIFY THE COST, NO MATTER HOW SMALL. I FEAR THAT ALL THREE PROPOSALS ARE TOO TIMID. WE MUST BE BOLD IN OUR EFFORTS, WITHOUT KILLING THE MOMENTUM BY ADDING TOO MUCH "BAGGAGE".

LAST, AS WE REVIEW WHAT IS ESSENTIALLY AN "ADD-ON" TO MEDICARE, WE SHOULD NOT IGNORE THIS OPPORTUNITY TO REVIEW THE BASIC MEDICARE BENEFIT. THAT IS, ARE THERE BENEFITS NOW PROVIDED BY MEDICARE THAT NEED TO BE RESTRUCTURED OR EXPANDED IN ORDER TO PREVENT ILLNESSES FROM BECOMING CATASTROPHIC FINANCIAL BURDENS. I AM THINKING IN PARTICULAR ABOUT THE MENTAL HEALTH BENEFIT, WHICH IS SORELY LACKING AND MAY CONTRIBUTE TO CATASTROPHIC COSTS BECAUSE IT LEADS TO INAPPROPRIATE OR INDADEQUATE HEALTH CARE. SERIOUS LIMITATIONS ON THE SKILLED NURSING AND HOME HEALTH BENEFITS ALSO SHOULD BE REVIEWED. I COMMEND SEN. DOLE FOR ADDRESSING AT LEAST A PORTION OF THE HOME HEALTH BENEFIT IN HIS BILL.

MR. CHAIRMAN, I AM CONFIDENT THAT WE CAN FASHION A CATASTROPHIC PACKAGE THAT WILL BE A SIGNIFICANT STEP FORWARD. TO THAT END, I LOOK FORWARD TO HEARING THE SUGGESTIONS AND CRITICISMS FROM THE DISTINGUISHED PANELS OF ELDERLY CONSUMER REPRESENTATIVES AND HEALTH CARE PROVIDERS THAT YOU HAVE CALLED TOGETHER TODAY.

Congressional Research Service
The Library of Congress

Washington, D.C. 20540

COMPARISON OF SELECTED MEDICARE CATASTROPHIC INSURANCE BILLS

Prepared According to the Instructions of the Senate Finance Committee

Janet Lundy
Richard Price
Specialists in Social Legislation
Education and Public Welfare Division
March 18, 1987

Comparison of Selected Medicare Catastrophic Insurance Bills

	S. 592/H.R. 1245 (Administration bill)	H.R. 1280/H.R. 1281 (Stark et al.)	S. 754 (Dole et al.)
1. General approach	The bill provides Medicare catastrophic coverage for those persons voluntarily enrolling in Part B by limiting beneficiary cost-sharing amounts for certain Medicare-covered services. For all Medicare beneficiaries, the bill provides unlimited inpatient hospital days, repeals inpatient hospital coinsurance, requires no more than two inpatient hospital deductibles per year, provides for 100 days of skilled nursing facility (SNF) care per year, and eliminates SNF coinsurance charges. The catastrophic coverage and benefit changes would be financed by an increase in the monthly Part B premium, which would be adjusted annually to cover the cost of the catastrophic coverage and benefit changes.	The bill provides Medicare catastrophic coverage for those persons voluntarily enrolling in Part B by limiting beneficiary cost-sharing amounts for certain Medicare-covered services. For all Medicare beneficiaries, the bill provides unlimited inpatient hospital days, repeals inpatient hospital coinsurance, requires only one inpatient hospital deductible per year, provides for 150 days of skilled nursing facility (SNF) care per year, requires SNF coinsurance charges for the first / days only, revises the calculation of SNF coinsurance charges, and expands the hospice benefit. The catastrophic coverage and benefit changes would be financed by including a portion of the actuarial value of Medicare benefits as taxable income for Medicare beneficiaries.	The bill provides Medicare catastrophic coverage for those persons voluntarily enrolling in Part B by limiting beneficiary cost-sharing amounts for certain Medicare-covered services and immunosuppressive drugs, providing unlimited inpatient hospital days, eliminating inpatient hospital coinsurance, requiring only one inpatient hospital deductible per year, and eliminating SNF coinsurance charges. For all Medicare beneficiaries, the bill also expands coverage for home health services. The catastrophic coverage and expanded benefits would be financed by an increase in the monthly Part B premium sufficient to cover the costs of the catastrophic program, with a limit on the premium increase tied to the increase in Social Security benefits.

Comparison of Selected Medicare Catastrophic Insurance Bills

	S. 592/H.R. 1245 (Administration bill)	H.R. 1280/H.R. 1281 (Stark et al.)	S. 754 (Dole et al.)
2. Hospital benefit			
a. Number of days	Provides for unlimited inpatient hospital days.	Provides for unlimited inpatient hospital days.	Provides unlimited inpatient hospital days for those with catastrophic coverage.
b. Coinsurance	Repeals inpatient hospital coinsurance charges.	Repeals inpatient hospital coinsurance charges, including those required for emergency hospital services provided by a hospital that does not participate in Medicare.	Medicare would pay 100% of inpatient hospital coinsurance charges for those with catastrophic coverage.
c. Deductible	Requires no more than two inpatient hospital deductibles per year, and these could be counted toward the catastrophic limit.	Requires only one inpatient hospital deductible for the first period of continuous hospitalization that begins in a calendar year. Beneficiaries whose spell of illness begins before Jan. 1, 1988 and ends after that date would not be required to pay an additional deductible during that spell of illness during 1988 or 1989. Provides that the deductible would be $520 for 1987, increased in subsequent years by the cost-of-living adjustment for Social Security benefits.	For those with catastrophic coverage, the first inpatient hospital deductible per year would count toward the catastrophic limit, and Medicare would pay 100% of any additional deductibles in that year.

Comparison of Selected Medicare Catastrophic Insurance Bills

	S. 592/H.R. 1245 (Administration bill)	H.R. 1280/H.R. 1281 (Stark et al.)	S. 754 (Dole et al.)
2. Hospital benefit (continued)			
d. Spell of illness	Repeals the spell of illness concept.	Repeals the spell of illness concept.	Retains the spell of illness concept.
e. Adjust PPS rates	No provision.	When adjusting the PPS rates, requires the Secretary to take into account reductions in beneficiary payments to hospitals resulting from the repeal of the day limit on inpatient hospital services.	No provision.
f. Psychiatric inpatient benefit	Repeals the requirement that if a beneficiary is an inpatient of a psychiatric hospital on the first day of Medicare entitlement, the days on which (s)he was an inpatient during the immediately preceding 150 days are subtracted from coverage available in the initial spell of illness.	No provision.	No provision.
3. SNF benefit			
a. Number of days	Provides for 100 days of care per year.	Provides for 150 days of care per year.	No provision. (Current law allows 100 days per spell of illness.)

Comparison of Selected Medicare Catastrophic Insurance Bills

	S. 592/H.R. 1245 (Administration bill)	H.R. 1280/H.R. 1281 (Stark et al.)	S. 754 (Dole et al.)
3. SNF benefit (continued)			
b. Coinsurance	Repeals SNF coinsurance charges.	Requires beneficiaries to pay coinsurance amounts for the first 7 days only. Provides that coinsurance amounts would equal 20% of the national average per diem Medicare reasonable cost for SNF services.	Medicare would pay 100% of coinsurance charges for those with catastrophic coverage.
c. Spell of illness	Repeals the spell of illness concept.	Repeals the spell of illness concept.	Retains the spell of illness concept, but modifies it to allow certain patients in a SNF to start a new spell of illness although they have not left the SNF for the required 60 days.
4. Home health	No provision.	No provision.	For all Medicare beneficiaries, provides for nursing care and home health aide services on a daily basis for 21 days with physician certification.
5. Hospice	Counts hospice coinsurance charges toward the catastrophic limit.	Provides for a subsequent extension period beyond the current 210-day limit.	For those with catastrophic coverage, hospice coinsurance amounts would count toward the catastrophic limit.

Comparison of Selected Medicare Catastrophic Insurance Bills

	S. 592/H.R. 1245 (Administration bill)	H.R. 1280/H.R. 1281 (Stark et al.)	S. 754 (Dole et al.)
6. Blood deductible	No provision.	Provides that beneficiaries would be required to pay one Part A blood deductible per year, rather than per spell of illness. Provides that the blood deductible could be reduced by replacing the blood. Provides that the Part B blood deductible would not be required after the catastrophic limit is reached.	For those with catastrophic coverage, Medicare would pay 100% of the Part A blood deductible and would count the Part B blood deductible toward the catastrophic limit.
7. Drugs	No provision.	No provision.	For individuals receiving an organ transplant paid for by Medicare, counts the 20% coinsurance for immunosuppressive drugs during the first year after the transplant and all reasonable charges for such drugs in subsequent years toward the catastrophic limit. Requires the DHHS Secretary to request the National Academy of Sciences to identify additional drugs, available by prescription only, which could be counted toward the catastrophic limit.

Comparison of Selected Medicare Catastrophic Insurance Bills

	S. 592/H.R. 1245 (Administration bill)	H.R. 1280/H.R. 1281 (Stark et al.)	S. 754 (Dole et al.)
8. Catastrophic limit			
a. Limit	$2,000 for 1988, indexed in future years to percentage changes in total Medicare per capita expenses.	$1,000 for 1988, indexed in future years to increases in the Social Security cost-of-living adjustment.	$1,800 for 1988, indexed in future years to percentage changes in the Consumer Price Index.
b. Expenses counted toward limit	Beneficiary out-of-pocket expenses for the inpatient hospital deductible, coinsurance under the hospice benefit, and for Part B services (the Part B deductible, the Part B blood deductible, and the 20% Part B coinsurance). Expenses occuring in the last quarter of the previous year may be substituted for those in the last quarter of the current year, if greater.	Beneficiary out-of-pocket expenses for Part B services (the Part B deductible, the Part B blood deductible, and the 20% Part B coinsurance).	Beneficiary out-of-pocket expenses for the first inpatient hospital deductible, hospice care coinsurance, Part B services (the Part B deductible, the Part B blood deductible, and the 20% Part B coinsurance), and the coinsurance in the 1 year after transplant and reasonable charges in subsequent years for immunosuppressive drugs.
c. Medicare payment after limit is reached	100% of beneficiary cost-sharing amounts for the inpatient hospital deductibles, hospice care coinsurance, the Part B deductible, and covered Part B services when the catastrophic limit is exceeded for that year.	The Part B deductible and 100% of the reasonable charges (in some cases, the reasonable costs) for covered Part B services when the catastrophic limit is exceeded for that year, and the beneficiary would not be required to pay the Part B blood deductible.	100% of beneficiary cost-sharing amounts for the first inpatient hospital deductible, hospice care coinsurance, the Part B deductible, covered Part B services, and the coinsurance for immunosuppressive drugs in the first year after the transplant when the catastrophic limit is exceeded for that year.

Comparison of Selected Medicare Catastrophic Insurance Bills

	S. 592/H.R. 1245 (Administration bill)	H.R. 1280/H.R. 1281 (Stark et al.)	S. 754 (Dole et al.)
9. Financing	Finances the catastrophic coverage and the benefit changes by an increase in the current Part B monthly premium sufficient to cover the costs of these changes. The additional premium amount would be adjusted annually so that the premium covers the costs of the catastrophic coverage and benefit changes. Provides for periodic transfers from the Part B Trust Fund to the Part A Trust Fund of amounts which are attributable to expenses resulting from the Part A benefit changes made by this bill.	Finances the catastrophic coverage by including the following in taxable gross income: for beneficiaries entitled to Medicare Part A, 50% of the Medicare Part A per capita actuarial value; for beneficiaries entitled to Medicare Part B, 75% of the Part B per capita actuarial value. Provides that individuals who pay a premium for Part A coverage, and citizens and nonresident aliens who have been continuously outside the U.S. for 2 years would not be taxed unless they received payment from Medicare for health care services during the year. Provides that tax liabilities received from beneficiaries entitled to Part A would be transferred from the general fund of the Treasury to the Federal Hospital Insurance Trust Fund.	Finances the catastrophic coverage by an increase in the current Part B monthly premium sufficient to cover the cost of the catastrophic coverage. The additional premium amount would be adjusted annually so that the premium covers the costs of the catastrophic coverage; however, in 1988, the premium for any beneficiary would not increase beyond the increase in Social Security cash payments that results from a COLA increase.
10. Medigap requirements	No provision.	No provision.	Provides that if the National Association of Insurance Commissioners (NAIC) revises existing model regulations for Medicare supplemental

Comparison of Selected Medicare Catastrophic Insurance Bills

	S. 592/H.R. 1245 (Administration bill)	H.R. 1280/H.R. 1281 (Stark et al.)	S. 754 (Dole et al.)
10. Medigap requirements (continued)			health insurance policies within 90 days of enactment of this bill, then such revisions would be used, beginning 1 year later, as the standard for certifying such policies. If the NAIC does not revise such regulations, requires the DHHS Secretary to issue Federal model standards within 90 days, which would become effective 1 year later.
11. HMO payment provisions	No provision.	Requires the Secretary to provide for an appropriate adjustment in payment amounts to HMOs.	Requires the Secretary to provide for an appropriate adjustment in payment amounts to HMOs and renal dialysis facilities.
12. Effective date	Applies to items and services furnished after, and premiums for months after, 1987 (except expenses incurred in the last quarter of 1987 may count toward the catastrophic limit).	Generally applies in 1988.	Applies to items and services furnished after, premiums for months after, and spell of illness determinations after 1987. The home health change would apply to services on or after Oct. 1, 1987.

The CHAIRMAN. The hearing will come to order.

We are very pleased to have with us this morning Senator Domenici, the ranking Minority member of the Budget Committee, and I understand he has a statement he would like to make at this time.

STATEMENT OF HON. PETE V. DOMENICI, A U.S. SENATOR FROM THE STATE OF NEW MEXICO

Senator DOMENICI. Thank you very much, Mr. Chairman. I appreciate your accommodating me and I am sure I will take only a few moments.

First, I want to compliment you on expediting the hearings on catastrophic health insurance. It was my privilege within the last week to introduce, along with Senators Dole, Danforth, Durenberger and Chafee, a suggested approach to catastrophic health insurance. We call it the "Medicare Catastrophic Illness Coverage Act of 1987." The very title indicates that we want to build, as a first effort, upon some existing systems so we can get something done quickly. So there should be no misunderstanding, this bill basically addresses the Medicare issue in terms of catastrophic health.

We have all had an opportunity in our respective states to talk to people about the kinds of problems that catastrophic illnesses bring to their lives. I had such an occasion in New Mexico. I even heard from one young lady who testified that she had a $250,000 series of bills. She was extremely courageous. I couldn't believe she made it through the episode, but she did. And she had some very constructive suggestions, obviously. So did people in my State who represent the elderly.

I need not remind the committee of the catastrophic health expenses that the senior citizens under Medicare are incurring. And I need not remind this committee that somewhere between one and a half and three and a half percent of all Americans are incurring catastrophic health expenses in any one year.

The bill that we recommend you seriously consider and work from, as I indicated, is limited to senior citizens and to Medicare; however, I think it does a lot of good things. First of all, it limits the beneficiary's out of pocket cost to $1,800.00, indexed to the CPI. It also limits to one the number of hospital deductibles, currently $520.00, which a beneficiary may incur in one year. And, it eliminates the current inpatient deductible for whole blood. The premium cost of this proposal is approximately $9.00 per month.

We have a hold harmless provision in our bill and have run that through CBO, indicating that it remains budget neutral. But that hold harmless is important because no senior citizen on social security would suffer a reduction in the check they receive, even though they would be paying an additional $9.00 premium for this extended coverage.

There are a number of other things that obviously have to be done, and this bill accomplishes some of them. It removes current limits on the number of days that a patient can remain in a hospital and still receive Medicare benefits. It removes that restriction, which is the heart of the problem. It also eliminates all co-payments for skilled nursing facilities and addresses a number of other items.

The point I would like to make here today, Mr. Chairman, is that in our country, even though many thought in 1977, 1978, and 1979—in fact, I think a number of people right here introduced bills in 1979—that clearly, the time is right for us to pass a catastrophic health insurance bill.

The President is now supporting a bill. His secretary in charge of health is supporting that bill, and the concept. And I came here today obviously to support the notion that when the time is ripe we ought to pass legislation, and, secondly, to lend my support to your efforts; in a way, to lend my support to an aspect that you will have a great deal of difficulty with. Many people are going to want to cover all catastrophic illnesses, including nursing homes and those who are not under Medicare. I am sure that the chairman and the members of this Committee would like to do that also. But it seems to this Senator that we ought to take one big giant step and make sure we can get it done. To make sure that it is fiscally sound, and to make sure that it is something that can pass both houses and get signed by the President.

I want to thank you again for giving me a few moments of your very valuable time.

The CHAIRMAN. Thank you very much, Senator.

This is a continuation of the hearings on catastrophic illness to look at some of the alternatives that have been proposed. And we have just heard one of them from the distinguished Senator from New Mexico. This is an issue that I have been very mvch interested and concerned about since the 70s. In 1984 and again in 1985, I introduced legislation to protect Medicare beneficiaries against catastrophic acute care expenses.

We have heard from the Health and Human Services Secretary, Dr. Bowen, about his proposal. That has been endorsed by the President, and we are pleased to see that kind of initiative.

Today, we seek the views of groups representing America's elderly, as well as the provider community, about what should constitute a catastrophic insurance package.

Next week, we are going to hear from the experts about alternatives for financing catastrophic protection, but today I welcome the opportunity to hear from those of you who live every day with the reality of what a financially devastating illness can do to individuals who have already experienced a physical catastrophe.

This nation's elderly have a right to live out their lives in dignity without the fear that their financial security may evaporate if a long-term serious illness develops. I am especially interested in hearing from the beneficiary groups whose financial risk under Medicare has been dramatically affected by changes in the program since 1965. Medicare's benefit package, designed 22 years ago, before the advent of prospective payment, may now be outmoded. No longer need patients be encouraged to leave the hospital promptly by imposing ever increasing co-insurance levels.

Rather, the new DRG-based payment provides incentives for hospitals and doctors to discharge patients at the earliest possible time. As we had hoped, average lengths of stay have declined. But now we have to turn our attention to transition care for those persons who, on leaving the hospital, still require some professional services.

I believe any catastrophic insurance benefit will be incomplete if we don't do a better job of ensuring access to transitional care in skilled nursing facilities and home health agencies. Now these kind of services ease a patient's transition from a hospital and can help ensure a full recovery. Yet, ironically, the existing Medicare benefit package, particularly as currently interpreted, makes it even harder for patients to receive transitional care.

I also look forward to hearing from the provider community about how they currently finance care for elderly beneficiaries who exhaust their financial resources, particularly from those of you who specialize in treating patients with long and costly illnesses. It seems to me that this is one of the toughest jobs.

On February 26, Senator Dole and I introduced the Administration's catastrophic insurance plan developed by Dr. Bowen. At that time, I indicated that the President's plan is a good starting point for filling the gaps in Medicare coverage of acute care expenses. I recognize that many of you will tell us today that we need to do a lot more to help defray the cost of long-term nursing home care, and to extend coverage to the 37 million Americans who do not now have insurance coverage. And just as Senator Domenici, I am sympathetic to those concerns. But, frankly, I am not optimistic about the prospects for such major expansions now because of the magnitude of the deficit that we face this year and the next.

Under the pressing constraints of deficit reduction, we may be able to take only a few steps toward one shared goal, but I think they are a major steps. I ask your patience and your support as we continue our deliberations. I ask your advice and want your counsel, especially on how best to educate beneficiaries that Medicare coverage is limited, and that they need additional protection against certain types of health costs.

I am disturbed to note, for example, that 80 percent of Americans believe that Medicare pays for long-term chronic nursing home care. That is according to a recent survey. That is what they believe.

We have an opportunity here to improve understanding of the medicare program. And while admittedly small, the changes we approve are going to make a tremendous difference in the lives of some of the most vulnerable of our citizenry. While we do this, let's not raise false hopes or expectations that we just can't fulfill overnight. Rather, if we proceed carefully and responsibly, I think in the measure we pass through this committee we can deliver to America's elderly a real measure of financial protection and I am committed to that.

I yield to my distinguished colleague, the ranking Minority member, Senator Packwood.

Senator PACKWOOD. I have no statement, Mr. Chairman.

The CHAIRMAN. Senator Chafee.

Senator CHAFEE. Mr. Chairman, as the debate on catastrophic health care progresses it seems to me we have got to develop a definition of what is a catastrophic illness expense. And in my opinion, any health related crisis which has the potential of forcing an individual or a family into near poverty is catastrophic. And if we use this definition, any expense that has the potential of forcing an individual or a family into near poverty, if we use that definition, it seems to me it is clear that this health care crisis is not limited to hospital care, not limited just to hospital care, and it is not limited to just those over 65.

Now, for most of the elderly the risk of needing long-term care or entering a nursing home is truly their most paralyzing fear. And I don't think any elderly couple or individual should be forced into poverty before assistance will be provided for long-term care. But the need for protection from catastrophic illness is not limited just to the elderly, as I mentioned before. Those under 65 are also at risk. And the needs of the younger families and children with chronic illnesses or disabilities, I think, have to be also addressed.

More than one-third of those without any health care insurance live in families with incomes below the poverty level. There are other individuals who even if they could afford to purchase insurance are without access to private health care insurance. They cannot get it.

Finally, there are individuals with chronic illnesses who exhaust their private health care insurance and have no way to go but into poverty to qualify for Medicaid benefits.

So if we truly address the issues of catastrophic illness expenses in this committee, we have got to begin with a broad view of the problem and we have got to keep our mind open to the solutions. Now, I have got some suggestions.

I have developed a proposal called Medic America, MedAmerica. And this proposal will address the health care needs of those under the age of 65 as well as low income elderly individuals. And the bill would build on Medicaid in the following three ways:

First, it would sever the tie between Medicaid and cash benefit programs, like AFDC or SSI;

Second, the States would have the option to allow individuals, the so-called working poor, whose incomes are at or near the poverty level to purchase health insurance through Medicaid with an income adjusted premium not to exceed 5 percent of the individual family's adjusted gross income;

Finally, the States would have the option to allow persons with family incomes or resources in excess of 200 percent of the federal poverty level to purchase Medicaid benefits if they have been excluded from private health insurance coverage because of a medical impairment or disability or if they have exhausted their benefits under their private insurance plans.

Now, this is going to cost a lot of money I am sure and we are getting from CBO some estimates on it. And it is an ambitious proposal and it may not pass in total this year. But I think there are components of this bill which address the problems that we will want to solve this year and I think it is important to explore this approach, Mr. Chairman.

The balance of my statement I also would like to include in the record at this time if I could. Thank you.

The CHAIRMAN. Without objection it will be done.

Senator Durenberger.

Senator DURENBERGER. Mr. Chairman, just a brief comment on my colleague from Rhode Island's statement.

I think he offers us an excellent challenge, and maybe it is a matter of clarifying the statement about one of the things we have learned here in the last few years is that you have to spend money to make or save money. And it strikes me that his suggestion for taking on the problems of the chronically ill under 65 and others in that position may appear to cost money in the initial stages in a budgetary sense, but in terms of the money it can save people in this country, both on the public and the private side, I would suggest that it is probably going to end up saving money. And I think it is going to be a valuable contribution to the discussion and the debate on catastrophic insurance.

Senator CHAFEE. Well, I want to thank Senator Durenberger for that comment, Mr. Chairman.

The CHAIRMAN. Thank you, gentlemen.

Our first panel will include John Denning who is the president of the American Association of Retired Persons, from Clinton, North Carolina. If you will come forward and take a seat, please. And Mr. William Hutton who is the executive director of the National Council of Senior Citizens, from Washington, D.C. And an old friend, Wilbur Cohen, professor of public affairs, the LBJ School of Public Affairs, from the University—and for the less sophisticated, that means the University of Texas—we are delighted to have you.

Professor Cohen.

STATEMENT OF PROF. WILBUR COHEN, PROFESSOR OF PUBLIC AFFAIRS, LBJ SCHOOL OF PUBLIC AFFAIRS, UNIVERSITY OF TEXAS, AUSTIN, TX

Professor COHEN. Thank you, Senator, for that introduction. And may I just say to some of the newcomers, this is the fifty-second year that I have appeared before the Senate Finance Committee.

The CHAIRMAN. How many?

Professor COHEN. Fifty-two years.

Senator CHAFEE. Who was the chairman? [Laughter.]

The CHAIRMAN. Russell Long. [Laughter.]

Professor COHEN. No, sir. Pat Harrison was the chairman. And I have spent many, many months, particularly in the back room, negotiating with the committee on Medicare and Medicaid in 1965, but this is the first time I have been here, Senator, under your leadership, which those of us in Texas are very happy to have you here.

The CHAIRMAN. Thank you, sir.

Professor COHEN. And we are already organizing for two years from now. [Laughter.]

The CHAIRMAN. Well, you are obviously a man of great judgment. [Laughter.]

Professor COHEN. I have, Senator, knowing your shortness of time, given you a summary of what I intend to testify on today, and while it might not be possible to go into all of the items, I urge you to look at them. And I will spend as much time as you are interested in them.

I have not included in my summary my proposals of how to finance all of the proposals before the committee. And if you would like to ask me about those questions, I would be glad to tell you my solution on how to finance it. But since that was not on the agenda today, I did not include them.

Second, I would like to point out to Senator Packwood, particularly, my point number D in which I have embodied in my testimony the Senator's proposal of some years ago about amending the Medicaid law. I would like to discuss that because I think that is highly urgent right now in connection with this catastrophic care, which I will try to develop.

First, Senator, let me say I would like to compliment you and Secretary Bowen and the President for proposing this particular improvement. For a person like myself who spent 15 years advocating Medicare and Medicaid, it is a great experience in my life now to come before this committee and find that the merits of Medicare and Medicaid have been bipartisanly supported. And that, to me, is a great step forward in political consensus in our country—a pragmatic realization that has made a great difference.

I do have several points on the Bowen proposal. I would like to see it compulsory, as in Part A of Medicare, rather than voluntary, because I think that that is the only way to keep Medicaid costs from continuing to go.

And, second, I would like to see the deductible decreased. And, third, I would not prefer as a financing mechanism putting the $4.92 a month on the aged beneficiary. I think that it is absolutely wrong to put the entire cost on the person at the time they are already aged and on a fixed income. My proposals for financing consider putting as much of the cost as feasible while people are working and while they have income.

But on my point C, I feel very strongly that whatever deductible you are going to put into effect, you should provide specifically that the States have to pay for that deductible under Medicaid for any person who is below about 133 percent of the poverty line. I think that otherwise, you are putting a sizable burden still on a lot of low-income aged people.

Now, recognizing the financial problems that we have in Texas at the present time, I realize putting that whole burden on the State of Texas, which has a very low Medicaid threshold of about 25 to 30 percent of the poverty line, may not be feasible. But I would suggest for your consideration two alternatives. One, that you pay 100 percent of the deductible cost under Medicaid for two years to give the States the opportunity to do that whenever you make the new program successful, or provide for about a 5 or 10 point increase in the federal matching ratio during the next two or three years in order that the States may do this at the point that you make it effective, or otherwise we are going to have a lot of burden either on Medicaid or the poor person.

In other words, I would like to see a complete buy in of Medicare by Medicaid or the deductible, whatever it is handled by Medicaid. But I would certainly, if you asked me my preference, I would say try to make the maximum deductible amount $520.00 indexed instead of $2,000.

And my next point is extremely important. I borrowed this from Senator Packwood. I would like to see you amend Medicaid by breaking it into two parts. One, the acute hospital care, and then making Title XXI a new title for all post-hospital medical care, including nursing home and long term care and complete community care for less than institutionalized medical care and not strictly limit it to health care, so that you could have nurses' aides, homemaker services, home health care, community care, respite care, Hospice care. Give the States complete financial incentive to keep people out of nursing homes, out of the hospitals, and try to make the federal matching ratio apply completely rather than thinking of it simply in a health context.

I believe if you look back at Senator Packwood's bill you will find that that is what he has tried to achieve.

The next point would be to do make a step in the direction of amending the Medicare law to provide some additional nursing home care. Not complete, because I think we need some more experimentation, but drop out the term "skilled" that is in the existing law for the 100 days that the present law does, and provide both nursing home care and skilled nursing home care and intermediate care, with possibly a deductible of $10.00 a day or some other amount that you want.

The CHAIRMAN. Professor Cohen, I will have to ask you to let us move on.

Professor COHEN. Yes, sir. The rest of my points are in the summary, Senator.

The CHAIRMAN. All right. Thank you. You have made some suggestions for program expansions we would like to do but are going to be pretty tough to do in this budgetary atmosphere.

Mr. Hutton.

[The prepared written statement of Professor Cohen follows:]

SUMMARY OF TESTIMONY OF WILBUR J. COHEN, FORMER SECRETARY OF HEALTH, EDUCATION, AND WELFARE, (1968) ON CATASTROPHIC HEALTH INSURANCE COVERAGE BEFORE THE SENATE COMMITTEE ON FINANCE, THURSDAY, MARCH 19, 1987

1. I endorse Secretary Bowen's proposed expansion of Medicare benefits, as far as it goes, but it does not go far enough to meet catastrophic needs. I recommend:

A. Reduction of the $2,000 deductible in the Bowen Medicare proposal to $750 or $1,000.

B. Reduction of the $4.92 a month Medicare premium to $2 a month and allocate the residual cost on an alternative and longer-run basis.

C. Amend the Medicaid law to require States to reimburse the deductible for all aged and disabled persons with incomes below 100 percent of the Federal poverty threshhold who do not have insurance which covers such a deductible, or to negotiate with hospitals to forego all or part of the deductible for such persons and to count such amounts as uncompensated charity care without any disadvantage to Medicare hospital reimbursement or repayment by the individual.

D. Amend the Medicaid law, effective October 1, 1989, by transferring reimbursement for all extended post-hospital care in a new title XXI and also provide for reimbursement of a full-range of alternative services such as homemaker, home care, visiting nurse, nurses aides. Provide for a two year financial incentive to States to adopt such services.

2. In addition to "skilled" nursing home services in Medicare add "nursing home" care (including intermediate care) to the range of services provided by Medicare.

3. Repeal the 3 day hospitalization eligibility rule or provide for the 3 day requirement to be met within one year before admission to a nursing home.

4. Extend nursing home care from 100 days to 183 days (6 months) with a $10 a day deductible after the 100 days.

5. Make the previous three changes effective July 1, 1989 to allow sufficient time for staff planning and preparation.

6. Repeal Diagnostic Related Group (DRG) reimbursement for hospitals, effective October 1, 1990 and substitute a negotiated cost-accounting formula to be promulgated by the Secretary of HHS, after consideration and review by a HIBAC (Health Insurance Benefits Advisory Council) consisting of representatives of hospitals, and medical experts and an equal number of consumers of Medicare and contributors.

7) Authorize the GAO to make periodic reports to the Congress on the proposed and actual administrative implementation of these amendments, the Board of Trustees to include annually specific cost estimates of each of the amendments for a five year period, and the Office of Technology Assessment to make a study and report on the policy aspects of the amendments with any recommendations by January 15, 1992.

8) I oppose any income-related Medicare deductible or benefit which would increase the administrative complexity of the program and undermine the insurance aspect.

STATEMENT OF WILLIAM HUTTON, EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF SENIOR CITIZENS, WASHINGTON, DC

Mr. HUTTON. Yes, sir. I am Bill Hutton, the Executive Director of the National Council of Senior Citizens.

If I may, sir, I would like to introduce my entire testimony which you have. I will just deal with a few highlights.

The CHAIRMAN. Yes, of course.

Mr. HUTTON. One of the greatest single catastrophic events an older American can face, both emotionally and financially, is being placed in a nursing home. Nursing home costs average $22,000 a year. Altogether, the elderly, in 1986, spent out of their own pockets $37.3 billion on health care, $16 billion of which was spent on nursing homes alone in this way. 1.6 million of the nation's elderly spent $16 billion, fully one-half of the nation's total nursing home bill, out of their own pockets.

In our opinion, continuing reliance on a public policy that withholds health care protection until and unless hard working citizens pauperize themselves is not something in which we can take pride. Clearly, faced with the problem in both financial and human costs, we need to find a more rational, well-coordinated approach to covering the catastrophic health care cost associated with the needs of long-term care.

Besides the obvious and tremendous cost of long-term care, Medicare cost sharing and out of pocket costs, especially for prescription drugs, are catastrophic for older Americans.

The elderly today spend the same proportion of their incomes in health care as they did before Medicare and Medicaid were established in 1965. In 1984, average out of pocket health care cost for the elderly accounted for 15 percent of their incomes, the same level that existed before Medicare was enacted. Not including nursing home and other long-term care expenses, the average annual out of pocket health expenses for the elderly reached $1,055.00 in 1984, more than three times the average amount of $310.00 spent by other Americans.

For elderly people not eligible for Medicaid but too poor to purchase a Medigap policy, staggering health care costs have become overly burdensome. Of the nearly 2.2 million seniors living below the federal poverty line, only 36 percent are covered by Medicaid. Another 6.2 million near poor seniors whose incomes are less than twice the federal poverty line are also not covered by Medicaid. These seniors who are the sickest and the poorest are exposed to health care costs equal to one-fourth to one-third of their income or about $1,300.00 a year.

First dollar coverage for the health care cost of this population is especially important since this population is much sicker than other elderly. Death rates are 50 percent higher than for Medicare beneficiaries. But despite their greater health needs, they receive 35 percent fewer physician visits, 29 percent fewer prescription drugs, and are 18 percent less likely to be admitted to a hospital.

Finally, there is the issue of the cap itself. According to figures we have seen, an estimated 96 percent of older people will never reach the $2,000.00 cap proposed under the Administration's plan.

The National Council of Senior Citizens has specific suggestions to make on how we might provide coverage for the three types of catastrophic illness faced by the nation's elderly—(1) coverage of long-term care costs; (2) providing, first dollar protection for low and lower income elderly, as well as covering the cost of prescription drugs; and (3) expanding the population to be assisted by the catastrophic data.

The CHAIRMAN. Thank you, Mr. Hutton.

Mr. HUTTON. Thank you, sir.

The CHAIRMAN. I see your time has expired. But I cannot help to be reminded that I called a hearing on this before the Joint Economic Committee in 1984 and you testified. I find in Washington you have to say something 44 times at least before somebody says, oh, by the way, did you hear what he said? And I think we are talking about an idea whose time has finally come.

Mr. HUTTON. Well, I know the long time you have been interested in catastrophic care. I have been testifying, not as long as my good friend, Wilbur, here, but 26 years I have been testifying on behalf of the National Council in front of this committee.

The CHAIRMAN. Hang in there. [Laughter.]

Mr. Denning, we are delighted to have you. And Mr. Denning is the president of the American Association of Retired Persons. Would you proceed, sir?

[The prepared written statement of Mr. Hutton follows:]

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CATASTROPHIC HEALTH CARE AND THE ELDERLY

Testimony Presented Before the
Senate Finance Committee

By

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March 19, 1987

First Vice President, Dr. Mary C. Mulvey, Providence, Rhode Island **Second Vice President,** George J. Kourpias, Washington, DC
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Thank you, Mr. Chairman, for holding this important hearing on catastrophic health care. You are certainly to be commended for your leadership in this extremely important issue and we look forward to working with you.

Catastrophic health care coverage is a very important issue, but it is not a new one, as you well know. I have been presenting testimony on this issue before Congressional Committees for the past 20 years. I have listened to the testimony of the Secretaries of the Departments of Health, Education and Welfare and Health and Human Services. In the 20 years that we have been discussing catastrophic illnesses and how to pay for them, we have always ended up with another study which lasts for a year and then is forgotten. We are now faced with a window of opportunity to make genuine improvements in Medicare, the likes of which we have not seen for many years--and may not see for many more.

Catastrophic costs generally look very different for the elderly than they do for the rest of the population. The elderly face three types of catastrophic costs: costs associated with the need for long-term care; out-of-pocket costs associated with both covered and uncovered health services, but particularly with the high cost of prescription drugs for middle- and low-income people; and, catastrophic costs associated with long-term hospitalization where neither Medicaid nor Medigap offers protection. Unfortunately, the Administration's plan would not adequately address any of these crucial catastrophic health costs faced by older Americans.

One of the single greatest catastrophic events an older American can face, both emotionally and financially, is being placed in a nursing home. Nursing home costs average $22,000 per year. Altogether, the elderly, in 1986, spent out of their own pockets $37.3 billion on health care, $16 billion of which was spent on nursing homes alone. In this way, 1.6 million of the nation's elderly spent $16 billion--fully one-half of the nation's total nursing home bill--out of their own pockets.

This is an enormous burden that the elderly and their families are forced to shoulder themselves. While most of the elderly think the Medicare program or their Medigap policies will help with these costs, this couldn't be much farther from the truth. Medicare expenditures for care in skilled nursing facilities equal only two percent of total national nursing home expenditures, and only one percent of the total Medicare budget. Similarly, private insurance covers only one percent of the nation's nursing home bill. The grim reality that many elderly are forced to face is that protection from these tremendous costs does not exist until they have spent themselves into poverty.

In our opinion, continuing reliance on a public policy that withholds health care protection until and unless hard-working citizens pauperize themselves is not something in which we can take pride. Clearly, faced with the problem in both financial and human costs, we need to find a more rational, well-coordinated approach to covering the catastrophic health care costs associated with the need for long-term care.

The National Council of Senior Citizens understands the realities of Gramm-Rudman-Hollings and the chilling effect the Federal deficit has on good public policy generally, and good health care policy specifically, and so we realize that comprehensive coverage of long-term care costs within a public health program may not occur as soon as we would like. Intermediate steps can be taken in this area, however, and other very serious catastrophic costs faced by the elderly certainly can and should be included in a catastrophic package that aims to provide useful protections for the elderly.

Besides the obvious and tremendous costs of long-term care, Medicare cost-sharing and out-of-pocket costs, especially for prescription drugs, are catastrophic for many older Americans. The elderly today spend the same proportion of their incomes on health care as they did before Medicare and Medicaid were created in 1965. In 1984, average out-of-pocket health care costs for the elderly accounted for 15 percent of their incomes, the same level that existed before Medicare was enacted. Not including nursing home and other long-term care expenses, the average annual out-of-pocket health expenses for the elderly reached $1,055 in 1984, more than three times the average amount ($310) spent by other Americans.

The elderly are financially liable, under the Medicare program, for many out-of-pocket costs associated with Medicare covered services, including premiums, co-insurance charges, deductibles and costs above the Medicare "reasonable" charge limit. These costs have soared in recent years, leaving the beneficiaries with ever-heavier financial burdens to bear. The Part A hospital deductible, for example, increased by 155 percent in the past six years, from $204 in 1981 to $520 in 1987--an increase five times as great as the overall rate of inflation. The annual Part B premium for physician and other costs has increased by 86.5 percent in six years, from $115.20 in 1981 to $214.80 in 1987, and out-of-pocket costs for physician charges above the Medicare "reasonable" charge limit increased 286 percent, since 1977, to $2.7 billion a year.

In addition to these costs for covered services, the elderly paid $7 billion out of pocket in 1981 for many vital health care needs not covered by Medicare, including prescription drugs, eyeglasses, hearing aids, dental care and physical examinations. For 75 percent of the elderly population, prescription drugs represent the largest out-of-pocket expenses they will face. Many elderly individuals take four to five drugs a day and, on average, fill at least 12 prescriptions every year. In fact, while people over age 65 represent only 12 percent of the population, they take 30 percent of all prescription drugs used in this country. Unfortunately, unlike most other health care costs, prescription drug costs are not covered by private health insurance or by Medicare out of the hospital. Medicaid will only cover the costs of prescription drugs for the indigent, or about six percent of the elderly's total drug expenditures. Only 20 percent of the elderly fall into one of these categories, leaving the remaining 80 percent to pay for these drugs out of their own pockets.

These costs are far from insignificant. The elderly's drug bill amounts to over $6 billion annually. Payments for drugs represent 20 percent of the elderly's total out-of-pocket health care costs and average $340 per person per year.

The extraordinarily high rate of inflation, and high rates of profit, in the prescription drug industry, are, in large part, accountable for the increased financial burden borne by the elderly in trying to pay for these costs. Last year, while medical care costs overall rose 7.7 percent, seven times as fast as the CPI, prices for prescription drugs outpaced all other medical costs by rising nine percent. Tranquilizers and sedatives, which are often prescribed for older people, posted the biggest price increase of 13.2 percent. At the same time, pharmaceutical corporations, in 1984, enjoyed profits of 13.2 cents on the dollar, compared to 4.6 cents for all manufacturers, in fact, profits in this industry have traditionally outpaced the average profit for all other industries by two and even three times.

For elderly people not eligible for Medicaid, but too poor to purchase a Medigap policy, staggering health care costs have become overly burdensome. Nearly 2.2 million seniors living below the Federal poverty line ($5,156 in 1985)--only 36 percent of the low-income elderly--are covered by Medicaid. Another 6.2 million near-poor seniors whose incomes are less than twice the Federal poverty line are also not covered by Medicaid. These seniors, who are the sickest and poorest, are exposed to health care costs equal to one-fourth to one-third of their income, or about $1,300 per year.

First-dollar coverage for the health care costs of this population is especially important since this group is much sicker than other elderly. Death rates are 50 percent higher than for all Medicare beneficiaries. But, despite their greater health needs, they receive 35 percent fewer physician visits, 29 percent fewer prescription drugs and are 18 percent less likely to be admitted to a hospital.

Typical out-of-pocket costs for a moderate spell of illness for a senior whose income is lower than the Federal poverty line, but is not low enough to quality for Medicare, can be catastrophic in the extreme.

Medicare Part A deductible = $520.00
Medicare Part B premium = $214.80
Medicare Part B deductible for physician services = $75.00, more if the physician does not accept Medicare assignment
Medicare Part B co-insurance on a physician bill of $2,575.00 = $500.00
Prescription drug bills = $500.00
Bills for eyeglasses, dental care, etc. = $250.00

Total typical health care costs equal $2,003, out of an income below $5,156.

At this rate, the poor and near-poor elderly could not realistically be expected to pay an additional premium for catastrophic protection and out-of-pocket health care costs to reach a cap, such as the one proposed by the President. This group of very vulnerable and financially depressed seniors needs protection long before the cap is reached. The idea behind catastrophic protection should be to enable citizens to avoid being wiped out financially before protection begins. For these seniors, even ordinary out-of-pocket costs would cause them to be wiped out, or more likely, to avoid getting needed health care altogether.

Finally, there is the issue of the cap itself. According to the figures we have seen, an estimated 96 percent of older people will never reach the $2,000 cap proposed under the Administration's plan. The National Council of Senior Citizens has specific suggestions to make on how we might provide coverage for the three types of catastrophic costs faced by this nation's elderly: 1) coverage of long-term care costs; 2) providing first-dollar protection for low and lower income elderly, as well as covering the costs of prescription drugs; and 3) expanding the population assisted by the catastrophic cap.

Although the long-term care issue presents dramatic financing problems that we may not be ready to face, there are concrete steps that can be taken to make long-term care more accessible and less catastrophic for the elderly. Specifically, the three-day prior hospitalization requirement for Medicare-covered skilled nursing care should be eliminated, along with all Medicare skilled nursing facility co-payments; a remedy to the problem of spousal impoverishment should be made an integral part of a catastrophic package; and the Medicare home health care benefit should be more clearly defined.

To address the need for first-dollar health care coverage for the poor and the near poor, states should be required, through the Medicaid program and possibly with an enhanced Federal match, to cover Medicare cost-sharing requirements and provide prescription drug coverage to all seniors below the Federal poverty line. Medicaid coverage of these costs would provide payment of all deductibles, premiums and co-insurance amounts required by the Medicare program. It would also entitle beneficiaries to physician services through assignment and would provide adequate coverage of prescription drugs costs for this very poor segment of our society. Congress should also explore the possibility of an optional "buy-in" to Medicaid for people over the age of 65.

In addition, Mr. Chairman, we believe there is ample justification for the inclusion of a prescription drug benefit for the general Medicare population. As we have said, these costs have risen dramatically and there is little insurance protection available. Moreover, we believe that there would be some offsetting savings to the Medicare program by offering such coverage.

In a soon-to-be released study performed by the Department of Pharmacy Practice of the University of South Carolina, it was found that, after the State of New Jersey implemented its Pharmaceutical Assistance to the Aged program (PAA), Medicare recipients had, on average, $238.50 less in in-patient hospital costs than had a comparable group in Pennsylvania where no program was offered. The study also showed that hospital lengths of stay could be reduced by offering a prescription drug program. One of the study's conclusions was that "it appears that savings in reduced hospital stays are greater than or equal to the expenditures for prescription reimbursements plus the program's administration costs."

The New Jersey program requires a $2.00 co-payment and links reimbursement to the Maximum Allowable Cost (MAC) system under Medicaid. We would suggest a benefit for older people that would require a $1.00 co-pay and a $200 deductible. The cost of such a program would be between $1.6 billion and $2 billion--about the same amount that would be raised through the coverage for state and local employees under Medicare.

Mr. Chairman, over the past 20 years, 436 bills have been introduced in Congress to cover prescription drugs and still no action has been taken. As a result, although at least nine states have enacted plans, older people in 41 states still have no assistance. Our senior citizens have been calling for prescription drug coverage long and loud over this period of time and I hope you will act to include such a benefit in your legislation.

A lower catastrophic protection cap than the $2,000 level proposed by the Administration would help us achieve the goal of increased coverage for out-of-pocket costs for the rest of the elderly population. NCSC recommends that excess physician charges and prescription drug costs also be included to reach the cap. By not including these high-cost items, the cap would ignore a very significant portion of the elderly's health care costs.

As always, it's a lot easier to talk about what benefits should be provided under a public health care program than it is to determine who should pay for the added benefits. But, in this case, I think the answer is a fairly simple one--the burden should be shared. It is vital to keep in mind, as we discuss health policy and its effect on the deficit, that, since 1980, domestic programs serving the poor and the elderly have sustained deep cuts, even as citizens have suffered increased costs while receiving less than at the deficit has grown. As a result, many of our most vulnerable any time in recent history. The Medicare program's cuts already adopted will cost Medicare beneficiaries $14 billion over the next five years.

Clearly, the elderly did not cause our current budget deficit. The Congressional Budget Office (CBO) recently found that, if the budget and tax policies that were in effect when the Reagan Administration took office had been continued, rather than changed, the Federal deficit in FY 1985 would have been $80 billion (about the same as in 1981) rather than the $212 billion level at which the deficit now stands. The changes in defense and tax policy, along with the increase in interest payments on the national debt, caused by these policies, added $167 billion to the Federal deficit in 1985, meanwhile, domestic cuts--including reductions in Social Security, Medicare and Medicaid--reduced the deficit by $38 billion. The net result was an increase in the deficit of about $130 billion.

Let's keep in mind, then, that the elderly have done more than their fair share in being fiscally responsible and helping to reduce the Federal deficit. They have taken the cuts on the chin and in their wallets for seven years now and have asked for little in return.

There are, however, very real savings that can and should be found through the providers of health care in our country and, in fairness, savings from these cuts should be targeted to pay, at least in part, for any Medicare coverage expansion.

The NCSC urges the Committee to consider the possibility of rebasing the DRGs to factor in more current cost and efficiency data and using the resulting savings, which CBO estimates at $4.4 billion in the first year, to help finance new benefits for the elderly. Hospitals, under PPS, are still being paid based on 1981 cost data, even though significant cost and efficiency savings have resulted since implementation of PPS. In addition, some services formerly provided primarily on an in-patient basis, and included in the 1981 rates, are now provided in out-patient settings, or SNFs, where they are separately reimbursed on a reasonable cost basis. Lower, more accurate reimbursement rates would avoid what is, in effect, double payment for these services.

Nineteen eighty-four data is currently available on which DRG payment rates can be based. We firmly believe such action is warranted and fair, and that the resulting savings should be plowed back into the Medicare program.

Physicians should also be included in the finance design. Inclusion of hospital-based physicians' services in the PPS payments would raise $70 million in FY 1988, $170 million in FY 1989, and $240 million in FY 1990, for an impressive three-year total of $480 million.

NCSC recognizes that the elderly should participate in financing any kind of comprehensive benefit expansion. We believe the elderly's share should be progressively financed and should not overburden the poor, although we do not support taxing the actuarial value of the Medicare benefit. The Administration's proposal, with its reliance on a flat premium for all beneficiaries, runs the very real risk of increasing the burden on all beneficiaries in order to better protect only a few. The Administration's high cap, plus the additional premium, would place a much greater proportional burden on low- and middle-income beneficiaries, while it would hardly make a dent in the assets of a few. For these reasons, a progressive approach to beneficiary participation, with special allowances for the poor and the near poor, is vital to providing catastrophic protection for all elderly.

In addition, NCSC advocates the inclusion of state and local employees under the Medicare program. Since the majority of these citizens eventually rely on the benefits and protections provided by the Medicare program, we believe it is entirely fair that they also be required to take part in the financing of the program. Revenues generated by the proposal should be used to at least partially finance the Medicare benefit improvement under a catastrophic provision.

In conclusion, let me just make mention of a very important public service of which the elderly are sorely in need.

A separate, serious problem facing the elderly, that we all have a grave responsibility to address, is the issue of breaking the news to the elderly of America that the public programs they've relied on, and that they may rely on in the future, do not cover long-term care. I am very concerned, Mr. Chairman, that the public at large, but seniors especially, are being given a very false sense of security in thinking that the Administration's plan will provide for the costs of long-term care.

Already, a large portion of the Medicare population believes the Medicare program provides long-term care coverage--a belief they've been allowed to keep for far too long. Now, just as they're beginning to hear that this may not be the case, the Administration is holding out a new plan that, in the words of the President, will "give Americans that last full measure of security."

The greatest financial fear of many older Americans is the spectre of nursing home care and the last full measure of security they can be given is protection from the costs of long-term care. The President's comments, I greatly fear, will only cause seniors to shift from one false hope of relying on the Medicare program to answer these needs to another of relying on the catastrophic plan that the Administration has proposed.

I think it's very important that we go forward with a Medicare improvement plan, but I feel very strongly that it is incumbent upon all of us involved in shaping this public policy that we are very clear in describing just what the plan will--and won't--do for prospective beneficiaries. It would, in our opinion, be absolutely unconscionable if we were at all misleading. If the plan would not include long-term care benefits, that message needs to get across. NCSC will do its part in trying to ensure that Medicare beneficiaries and their families have factual, full information on which to base their decisions on planning for future needs. Medicare beneficiaries must not be lulled into a pleasant, but erroneous, belief that their long-term care needs will be met by paying $4.92 a month more in Medicare premiums.

Finally, we must not fail to recognize the fact that the plans under discussion deal only with the elderly population. NCSC recognizes and sympathizes with the plight of 37 million younger Americans who have no health insurance at all. Catastrophes affect people of all ages and something must be done to help these people as well. Mandating employers to provide health insurance is one step. But, we should also consider requiring states to provide Medicaid coverage to all those below the poverty line. A major step was taken in this direction in the last Congress and we must continue to press for such a Medicaid expansion.

Thank you, again, Mr. Chairman, for the opportunity to testify and present our views on the need for catastrophic health care protection this morning. Your leadership is invaluable to the senior citizens of this nation. We hope our suggestions have been helpful and we sincerely hope you will continue to call on us in the future as we look for compassionate, reasonable solutions to the problems facing the elderly.

STATEMENT OF JOHN DENNING, PRESIDENT, AMERICAN ASSOCIATION OF RETIRED PERSONS, CLINTON, NC

Mr. DENNING. Thank you, Chairman Bentsen. On behalf of the more than 25 million members of the American Association of Retired Persons, I wish to thank you for this opportunity to state the Association's views on the problem of catastrophic illness.

The Association commends you, Mr. Chairman, and your colleagues for your interest in developing a catastrophic illness plan for older Americans. I will focus my remarks this morning on four areas, the first one being the source of catastrophic costs for older Americans; and the second is acute care cost; and the third deals with our Association's response to the Administration's catastrophic proposal; and the fourth one would be our own recommendations.

Indisputably, the most critical need for catastrophic protection for older Americans is for help with the cost of long-term care. Our first chart indicates nursing home stays account for 80 percent of the expense incurred by older people who experience very high out of pocket medical cost. For most older Americans, acute care illnesses are less likely than long-term illness to result in a catastrophic burden. But Medicare's coverage of acute care is by no means complete. Beneficiaries must pay deductibles and co-insurance for Medicare coverage services and must bear the full weight of the cost of non-covered medical services and goods.

About 70 percent of enrolees purchase private supplemental insurance plans to protect themselves from the gaps in Medicare's coverage. But there is great bearability in the coverage offered by such plans. They seldom provide protection against the cost of prescription drugs, balanced billing of physician's dental, optical and eye care, and nursing home care. Further, there are costs in premiums that may be high relative to the benefit return to the insured.

It is reassuring to believe that the Medicaid program will protect elderly people from catastrophic acute care costs, but this is not the case. In 1986, only 27 percent of elderly people with family incomes under $5,000 were covered by Medicaid. Who among the elderly are most vulnerable to acute care catastrophic costs? And the answer must include the 21 percent of Medicare beneficiaries whose insurance protection is not supplemented by Medigap or Medicaid.

As our second chart reveals, or shows, these individuals tend to be very old, poor and frail. Another group of particular concern is the 44 percent of poor elderly Americans who feel compelled to buy Medigap insurance but who must surely forego certain day to day essentials in order to do so.

Secretary Bowen's catastrophic proposal represent an important first step in the development of a valuable plan to protect Medicare beneficiaries from acute care catastrophic costs, but his proposal, which is now the Administration's proposal, is a minimal one. Its $2,000 cap on co-insurance and deductibles would hardly protect an elderly person of limited means from financial catastrophe.

Further, the plan offers no protection for extended nursing home care, prescription drugs, balanced billing, or position envision in hearing care.

The Administration's proposal may strengthen Medicare, but it is misleading to label it a catastrophic plan.

The Association advocates the development of a benefit improvement incorporated in a catastrophic cap, but it is more comprehensive than the Administration's plan. Our package would deal with acute care, a 1-hospital deductible, the elimination of hospital coinsurance and lifetime limits, a thousand dollar cap Medicare Part B, a prescription drug benefit, and Medicaid improvements which we view as inseparable from the cap.

For transitional care, we would improve the skilled nursing facility benefit, and others. Under long-term care, the component would include protection against spousal improvement, impoverishment and expansion of home and community-based waivers.

Now, we have also included some ideas of payment, and that would include tobacco tax. It would include expanding of the base. But modest benefit package justifies an approach that doesn't put the burden of payment on difference source of income from the elderly.

So, finally, the Association cannot in good conscious support filling the gaps in Medicare's coverage while at the same time ignoring inadequacy in health insurance coverage for American workers and its children as was mentioned earlier.

Moreover, whatever the outcome of this year's initiative on catastrophic illness, let us be certainly scrupuously correct in characterizing to the American public what we have and possibly, more importantly, what we have not accomplished in our initial effort to correct this problem.

The CHAIRMAN. Thank you very much, Mr. Denning. Given our time constraints, I will have to ask you to conclude. Thank you.

[The prepared written statement of Mr. Denning follows:]

AARP

STATEMENT

of the

AMERICAN ASSOCIATION OF RETIRED PERSONS

on

EXPANDING MEDICARE TO INCLUDE CATASTROPHIC COVERAGE

Presented by:

John Denning, President

before the

SENATE FINANCE COMMITTEE

March 19, 1987

American Association of Retired Persons 1909 K Street, N.W., Washington, D.C. 20049 (202) 872-4700
John T. Denning *President* Cyril F. Brickfield *Executive Director*

Thank you, Chairman Bentsen. On behalf of the more than 24 million members of the American Association of Retired Persons, I wish to thank you for this opportunity to state the Association's views on the problem of catastrophic illness.

Before I begin, however, I would like to say that the Association is gratified by the current congressional and public interest in the problem of high cost illness and its impact on the citizens of this country. We believe that the public debate on catastrophic illness will lead to a more complete and more accurate understanding of the problem; the debate itself is, in our view, a critical step in the development of workable, appropriate solutions to a complex but hardly intractable social problem.

Let me say, at the outset, that the Association commends Chairman Bentsen and the members of this committee for your work towards the development of catastrophic health protection for the American public.

I will focus my remarks this morning on four areas: the major source of catastrophic costs for older Americans; the nature of the acute care catastrophic experience among older Americans; proposals by the Administration and the Chairman, ranking member, and other members of this committee to address elements of the catastrophic problem; and finally, recommendations by the Association, building in part upon the work of Secretary Bowen, and proposals emerging from the Senate and the House.

THE MAJOR SOURCE OF CATASTROPHIC COSTS FOR OLDER AMERICANS

Let us be clear this morning about the source of catastrophic costs for this country's senior citizens. Indisputably, the most critical need for catastrophic protection for older Americans is for help with the costs of long-term, chronic illness. As Chart 1 indicates, nursing home stays account for over 80% of the expenses incurred by older people who experience very high out-of-pocket costs for health care (over $2,000 per year).

The need for long-term care leads almost inevitably to an unmanageable financial burden because the costs of care--be it in an institution or in the home--are often enormous. Chart 2 shows the amount that an individual would pay for a 12-month stay in a nursing home and for modest medical expenses during that year. At more than $20,000 each year, few families could survive such expenses without severe financial hardship. Medicare and private insurance combined pay only a miniscule proportion of nursing home costs (less than 3% in 1985). More than half of nursing home costs are paid out of the pockets of residents or their families. Most of the remaining costs are paid under Medicaid, a means-tested welfare program. To qualify for Medicaid, one must either be poor or reduced to poverty in the process of trying to pay for care.

Few people can afford the expense of an extended nursing home stay, so many eventually end up on Medicaid, but only after financial catastrophe has occurred. Fully one-half of Medicaid dollars for nursing home care is spent on behalf of persons who enter nursing homes as private paying residents. The process of "spending-down" one's income and depleting one's assets to qualify for Medicaid can occur very quickly. A 1985 study conducted for the House Aging Committee found that approximately 2/3 of single older persons and 1/3 of older couples in Massachusetts were impoverished after only 13 weeks in a nursing home.

As such statistics indicate, the impoverishment of a spouse in the community in order to finance the care of an institutionalized mate is one of the most serious problems facing older couples today. To be eligible for Medicaid, couples must often spend-down their combined income and assets, leaving one spouse--usually the wife--destitute. Many of the same women who are caught in the spend-down problem have spent years taking care of ill and disabled husbands at home.

Personal care services of indefinite duration in the home are not covered at all by Medicare, and the amount and type of home care provided under Medicaid is extremely limited in most states. Even those who can afford to pay for home health and other in-home services face often insurmountable barriers in locating competent, trained personnel. As a result of both limited access to home care and the very high expense of nursing home care, many older persons live in fear of becoming a burden on their families, or being forced to enter a nursing home and spend their lifetime savings in order to pay for care.

THE ACUTE CARE CATASTROPHIC EXPERIENCE AMONG OLDER AMERICANS

For older Americans who have Medicare coverage, an acute care illness is less likely to result in a catastrophic burden than a long-term illness. But Medicare's coverage of acute care is by no means without significant gaps, gaps which if not supplemented by other forms of insurance, leave individuals vulnerable to devastating medical costs. Chart 2 shows that a Medicare beneficiary with two hospital stays would, on average, incur out-of-pocket expenses that would total nearly $3000 without private supplemental insurance and would even result in expenses over $1600 with an average insurance policy.

Medicare beneficiaries' liability for acute care medical costs consists of two components: (1) Medicare cost-sharing requirements (i.e., deductibles and coinsurance) for covered services, and (2) expenditures for non-covered medical services and goods. It is important to distinguish between these two categories of liability since most of the catastrophic "cap" plans that have been proposed permit the former (coinsurance and deductible amounts) to be counted toward the cap but exclude the latter (expenditures for non-covered services and goods). And the second category of liability is by no means insignificant; we estimate that, on average, for every $1.00 beneficiaries incur in coinsurance and deductibles, they spend an additional $.50 to $1.00 for non-covered services and goods.

1. Deductible and Coinsurance Liability

Under Medicare Part A, beneficiaries are required to pay a hospital deductible in each benefit period approximately equal to the cost of one day of hospital care ($520 in 1987). They are also responsible for coinsurance for days 61 through 90 equal to one-fourth of the hospital deductible. For each lifetime reserve day (days 91 through 150), beneficiaries are required to pay an amount equal to one-half the Part A deductible, or $260 per day in 1987. While there is no deductible for skilled nursing facility (SNF) services, Medicare beneficiaries this year will pay $65 per day to satisfy coinsurance requirements for days 21 through 100 in a SNF.

Approximately 23% of Medicare enrollees are admitted to a hospital at least once in a given year. But only about .5% of Medicare enrollees (158,000 in 1984) use more than 60 hospital days in a year, thereby triggering hospital coinsurance requirements.

In 1985, Medicare beneficiaries incurred $3.2 billion in Medicare hospital deductible and coinsurance liability. This amount represented an increase in such aggregate liability of more than 100% between 1980 and 1985. The largest portion of total Part A cost-sharing liability is attributable to the Part A hospital deductible.

Beneficiaries also share heavily in the cost of Medicare Part B services. Each beneficiary must meet a $75 annual Part B deductible, and is also responsible for 20% of the amount that Medicare deems "reasonable" for a particular Part B service. (In addition, beneficiaries whose doctors do not accept assignment are fully responsible for the amount their doctor charges above the Medicare-approved rate.)

Cost-sharing requirements under Medicare Part B represent a far greater financial burden on Medicare beneficiaries than do cost-sharing requirements under Part A. In 1986, Medicare beneficiaries incurred $5.7 billion dollars in Part B coinsurance liability and $1.7 billion dollars in Part B deductible liability. The most striking rate of increase in physician-related liability has occurred in coinsurance liability which in the aggregate has risen by 170% since 1980. Moreover, increases in Part B coinsurance expenditures have far outpaced increases in Social Security benefits.

Whereas only about one-fourth of Medicare beneficiaries will incur liability from the use of hospital services in a given year, 80% will incur liability from the use of physician services during the same period. Further only .5% of beneficiaries will trigger hospital coinsurance costs, but fully 60% of beneficiaries will incur coinsurance liability for physician services.

2. Medical Services and Goods Not Covered by Medicare

In addition to Medicare's cost-sharing requirements for covered services, beneficiaries also face significant out-of-pocket costs for those acute care medical services and goods which Medicare does not cover or which, in the case of certain services, are subject to Medicare's durational limits.

These acute care services and goods include:

- Outpatient prescription drugs
- Balance billing by physicians on non-assigned claims

- Dental services/products
- Optical services/products
- Hearing care services/products
- Routine physician examinations, influenza shots, Pap smears.

Out-of-pocket expenditures for these non-covered acute care services and goods can be staggering: more than $7 billion for outpatient prescription drugs in 1986; almost $3 billion for balance billing by physicians; more than $2.3 billion for dental care; and more than $1.4 billion for eye care.

3. Medigap's Role in Protecting Beneficiaries Against Catastrophic Costs

The gaps in Medicare's coverage, particularly its cost-sharing requirements, have led to the development of private supplemental insurance plans, so-called "Medigap" policies. About 70% of Medicare beneficiaries are covered by such plans. Since the enactment of the Baucus amendment in 1980, Medigap plans are required to cover: (1) hospital coinsurance; (2) 90% of Part A expenses after exhaustion of the lifetime reserve to a lifetime limit of 365 additional days; and (3) the 20% coinsurance on Medicare Part B services. Such plans are not required to cover either the hospital or physician service deductible, although most offer coverage of the former. Finally, the plans may impose their own deductible of up to $200 per year for Part B coverage.

In spite of the Baucus amendment, there is great variability in the depth and scope of coverage provided by Medigap plans. Most Medigap plans provide little or no coverage of prescription drugs, balance billing by physicians, dental services, and extended nursing home care. Moreover, the Baucus amendment does not apply to employment and labor organization-related group insurance, conversions from group plans to individual policies, and policies in effect before July 1, 1982. Finally, some plans may be very costly relative to the benefit returned to the insured.

It should be noted that supplemental coverage through a Medigap plan is positively correlated with income and education. Yet almost half of elderly people with less than $5000 per year in family income purchase Medigap plans (see chart 3). Even if the coverage selected is modest, the premium payments for such plans must constitute a terrible drain on already meager resources.

Let me at this point clarify the Association's position on the ability of the private insurance industry to protect older

Americans from the inadequacies of Medicare's coverage. The Association offers its members a Medicare supplemental insurance plan that fills many of the existing gaps in Medicare coverage. We believe, however, that filling such gaps through the Medicare program is inherently the most efficient way to insure against acute care catastrophic costs. Accordingly, we welcome any meaningful improvements in the Medicare program that will reduce the need for supplemental insurance plans or make them unnecessary.

4. Medicaid's Role in Protecting Beneficiaries Against Acute Care Catastrophic Costs

It is reassuring to believe that the Medicaid program serves to protect elderly beneficiaries from potentially catastrophic acute care out-of-pocket expenditures. But this is not necessarily the case. The Congressional Budget Office (CBO) reports that in 1986 only 27% of elderly people with family incomes below $5000 were covered by Medicaid (see chart 3). How can this be? We have only to look to the variability in Medicaid's eligibility requirements across states for an answer. There exists no national mandatory income standard for Medicaid eligibility, no mandated coverage of the "medically needy", and no uniformity in eligibility for a Medicaid "buy-in" of Medicare Part B coverage.

5. The Vulnerable Elderly

Who among the elderly are most vulnerable to acute care catastrophic costs? Surely the answer must include those who are not able to afford Medigap coverage, but who also do not qualify for Medicaid coverage. Such individuals tend to be frail, low-income, and uniquely vulnerable to the cumulative financial burden resulting from Medicare coinsurance and deductibles and from the costs of all non-covered services and goods. For nearly 21% of the elderly, Medicare represents the only source of protection (see chart 4).

A second group worthy of particular concern includes the poor/near poor who feel compelled to buy Medigap insurance but who can ill afford it. One can only surmize that such individuals must forego certain day-to-day essentials in order to purchase such protection (see chart 3).

THE ADMINISTRATION PROPOSAL

The Association is encouraged by the demonstrated interest of the Administration and the Congress in finding solutions to the problem of high cost illness for older Americans, although we are disappointed over the almost exclusive preoccupation with costs arising from acute care illness. The Administration proposal based on earlier recommendations of Secretary Bowen addresses only acute care costs, providing beneficiaries with unlimited hospital coverage subject to two deductibles each year and "capping" annual out-of-pocket expenditures for Medicare coinsurance and deductibles at $2000.

The Association recognizes that, through his recommendations to strengthen the Medicare program, Secretary Bowen took an important first step in the development of a viable plan to protect beneficiaries against acute care catastrophic costs. Nevertheless, it must also be recognized that the Secretary's catastrophic proposal -- now the Administration's catastrophic proposal -- is a minimal one. The $2000 cap on coinsurance and deductibles would hardly protect an elderly person of limited or even moderate means from financial catastrophe. Nor is it likely to persuade Medigap holders to drop their supplemental plans and self-insure for the first $2000 in coinsurance and deductibles.

Further, under the Administration plan, no out-of-pocket costs for the following services and products would count toward the annual cap: long-term nursing home care, out-patient prescription drugs, dental services, home health services, physical examinations, balance billing by "non-assigned" physicians, and optical supplies and services. The Administration plan may thus offer some improvement in Medicare's coverage, but it is misleading to suggest that it would provide older Americans with protection against catastrophic health care costs.

Secretary Bowen in developing his catastrophic proposal has given a matter of critical social significance visibility and credibility. He deserves credit for animating discussion and debate on the full range of catastrophic illness issues. Catastrophic proposals developed in the Congress advance this critical exchange of diverse ideas and help us to refine the elements of a workable, comprehensive plan.

AARP'S CATASTROPHIC PACKAGE RECOMMENDATIONS

One of the dilemmas policymakers face in attempting to set a protective "cap" on catastrophic costs is pinpointing the appropriate level for such a cap. Set the cap high, and the benefit can be financed without great difficulty; but as is clear from chart 5, few are protected under such an arrangement. As one pushes the cap down, the protective scope of the cap expands but the cost rises proportionately. Severely restrict the elements of liability which count toward the cap, and the plan becomes more affordable; the danger in this arrangement, of course, is that beneficiaries may wrongly assume that their total out-of-pocket liability in a given year will not exceed the cap level. As they gradually come to realize that a full range of essential medical services and products do not even count toward the "catastrophic" cap, they are apt to feel disappointed, if not duped.

It is important, then, that any plan that lays claim to providing _any_ level of catastrophic protection must identify and appropriately address actual sources of vulnerability. The Association believes that long-term care is the _real_ source of catastrophic costs for older Americans, including middle-income older Americans. We also believe that while acute care costs-- for both coinsurance and deductibles as well as non-covered services and goods including prescription drugs-- can threaten the financial security of many older Americans, they are potentially devastating to low-income elderly.

Given these concerns, the Association advocates the development of a benefit improvement that incorporates a catastrophic cap but is more comprehensive than the Administration plan and that, in our opinion, better balances the need for _acute care_ catastrophic protections with the need for _long-term care_ catastrophic protections. It also includes critical protections for low-income Medicare beneficiaries.

We do not delude ourselves in advancing the following set of recommendations that we have solved the catastrophic problem for older Americans. We do believe that in many respects our proposals expand, refine, and improve upon the efforts of others who have also grappled with this complex issue. Our proposals represent an earnest attempt to fulfill the President's pledge to protect Americans against catastrophic health care costs.

The benefit structure of the Association's package can be divided into three pieces:

1. Acute Care

2. Transitional Care

3. Long-term Care

Under the acute care component, we propose the following:

- One hospital deductible per year;

- Elimination of hospital coinsurance;

- Elimination of lifetime limits on hospital care;

- A $1000 cap on Medicare Part B cost-sharing (i.e., deductibles and coinsurance);

- A prescription drug benefit with a $200 annual deductible and a copayment on each filled prescription;

- Improvement in the Medicaid program through the establishment of a uniform mandatory income standard for Medicaid eligibility, and expansion of coverage through the Medicaid "buy-in" of Medicare Part B services. We view this element of the package as inseparable from the cap which, at $1000, is too high to adequately protect low-income beneficiaries.

Under the transitional care component, we recommend:

- Elimination of SNF coinsurance;

- Elimination of the three-day prior hospitalization requirement for SNF eligibility;

- An expanded home health care benefit;

- A respite benefit (carrying a 50% copayment) to provide assistance to caregivers.

Our long-term care component would include:

- Protection against spousal impoverishment including both income and liquid assets;
- Expansion of home and community-based services; and
- Exploration of the feasibility of capping out-of-pocket costs associated with long-term care.

FINANCING THE BENEFIT PACKAGE

The Association recognizes that, given a burgeoning federal deficit, the kind of improved benefit package we are recommending must be self-financed. Further, results of a recent AARP survey indicate a willingness among a majority of older people to pay increased premiums in return for significantly expanded benefits. Nevertheless, the full burden of the costs of the improved package we are advocating should not fall exclusively upon the elderly. To pay for the improvements we have described above, we propose using an assortment of financing sources, some targeted on improvements in the Medicare program and others targeted on Medicaid remedies. These potential revenue sources include:

Potential Revenue Source	Target	Estimated Yield
o Doubling of the tobacco tax	Medicaid	$2.9 billion (1988)
o Extension of HI coverage to state and local employees	Medicare	$1.3 billion(1988) $5.1 billion over 3 years
o Increase in the Part B Premium not to exceed an additional $10/month	Medicare	Up to $3.7 billion
		Total: $7.9 billion (1988)

The package we have proposed, would probably not represent a replacement for a typical Medigap plan. We believe, however, that responsible private insurers would respond with a corresponding offset (i.e. reduction) in Medigap premiums to match their reduction in risk exposure. Thus, the net additional cost in premiums to the 70% of Medicare beneficiaries carrying supplemental insurance could be minimal. As a complementary measure, our recommended Medicaid improvements would serve to protect those not currently covered by Medigap or Medicaid.

The proposal offered by some members of Congress to finance a catastrophic plan by taxing the actuarial or imputed value of that portion of the Medicare benefit that is not paid for by the employee during working years or through the Part B premium represents a radical departure from the financing mechanisms which presently support the Medicare program. While we encourage the exploration of innovative financing approaches to fund catastrophic protections, we are not convinced that a modest benefit package justifies the adoption of such a radical change in existing financing mechanisms. We believe that other financing options should be exhausted before we consider such an approach.

CONCLUSION

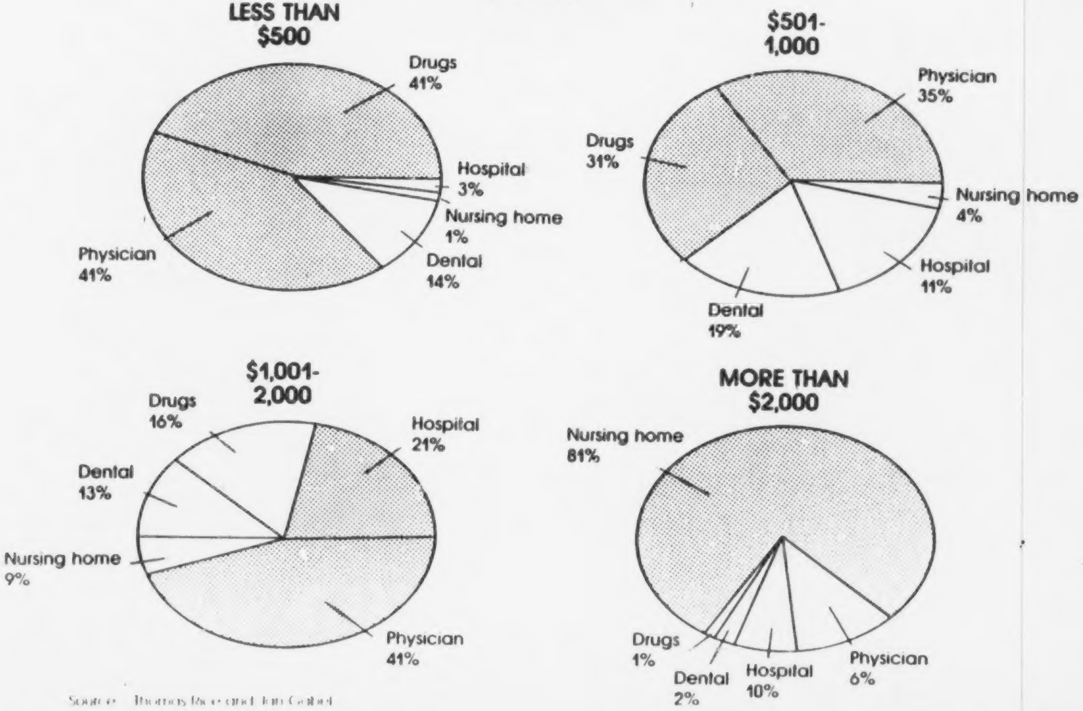
I would like to conclude my remarks this morning with two observations. First, we focus our attention here today on the plight of older Americans, many of whom struggle daily under the crushing weight of catastrophic medical costs. Initial action to address their plight is appropriate and, indeed, long overdue. But let us not forget the suffering of some 37 million Americans under the age of 65 who have neither public nor private health insurance. Surely a nation as richly blessed as ours in material wealth, wisdom, and compassion can summon the resolve to correct this terrible and intolerable social wrong. For our part, we cannot in good conscience support filling the "gaps" in

Medicare's coverage, while at the same time ignoring inadequacies in health insurance coverage for working Americans and our nation's children.

Finally, as we convene this morning, we do so with the realization that Congress is poised for action on catastrophic protections for older Americans. Whatever the outcome of this year's initiative on catastrophic illness, let us be scrupulously correct in characterizing to the American public what we have accomplished and, perhaps more importantly, what we have not accomplished in our efforts to come to grips with one of this country's most pressing social needs.

CHART 1

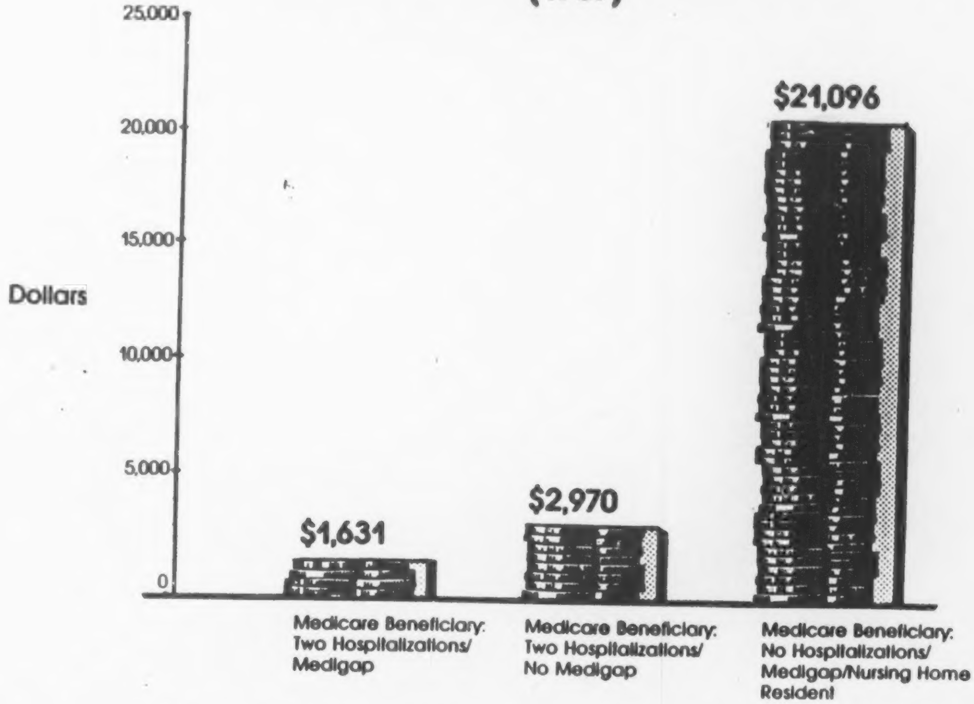
OUT-OF-POCKET COSTS BY TYPE OF SERVICE (1980)



Source: Thomas Rice and Jon Gabel
Health Affairs, Fall 1986.

CHART 2

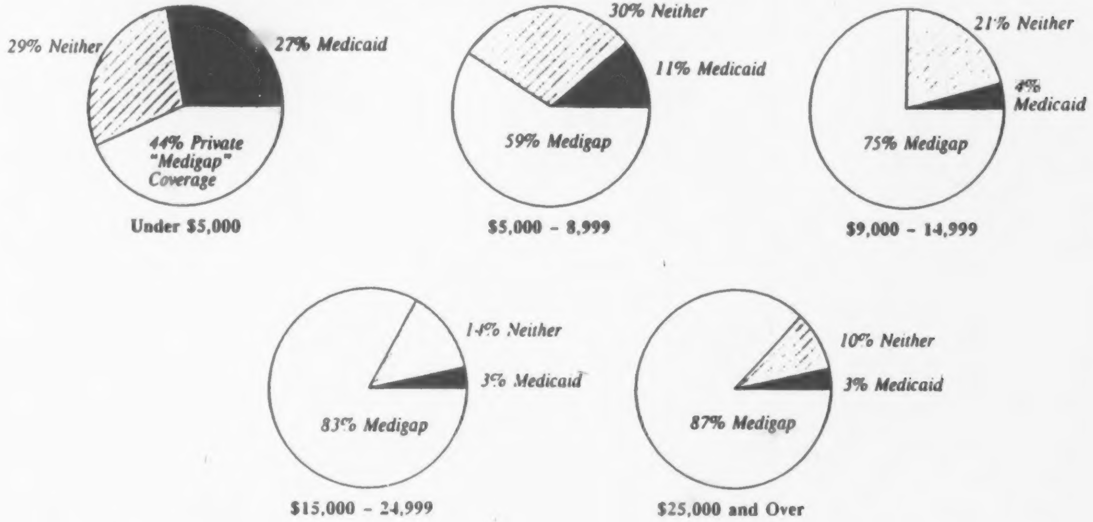
ANNUAL OUT-OF-POCKET MEDICAL EXPENSES FOR THREE MEDICARE BENEFICIARIES (1987)



Source Based on Congressional Budget Office preliminary estimates

CHART 3

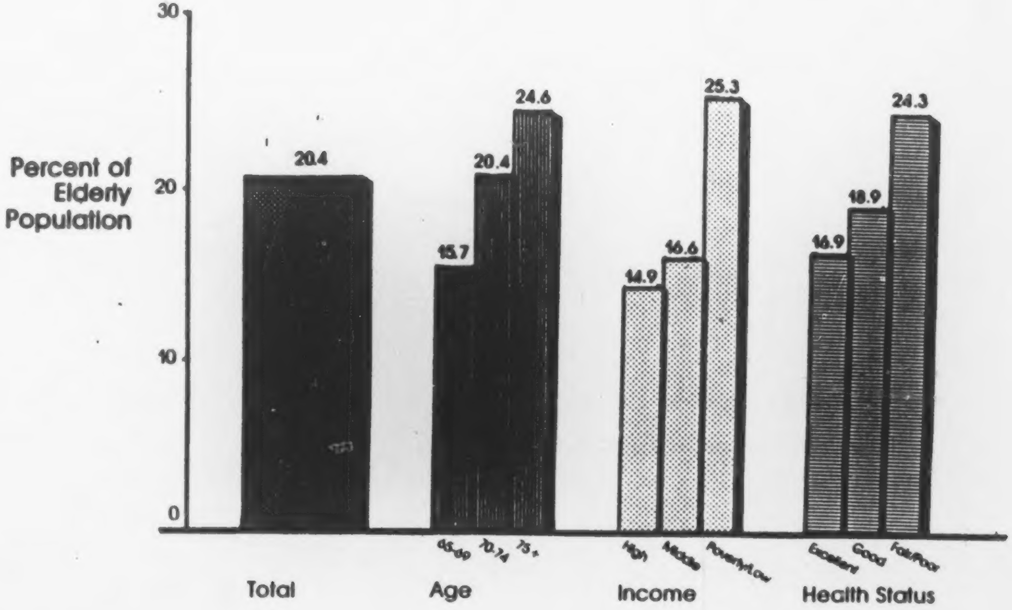
MEDIGAP COVERAGE FOR THE ELDERLY POPULATION BY FAMILY INCOME, 1986



Source: Congressional Budget Office.

CHART 4

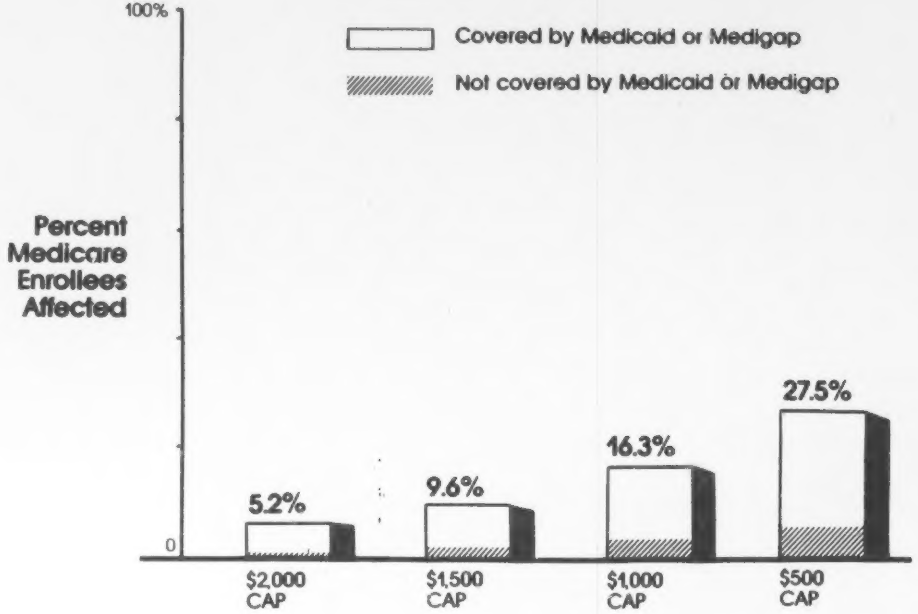
ELDERLY POPULATION WITHOUT PRIVATE HEALTH INSURANCE OR MEDICAID



Source National Center for Health Services Research

CHART 5

CATASTROPHIC CAPS: WHO BENEFITS?
(1988)



Source CBO Estimates

The CHAIRMAN. The questioning will be in order of the sequence of arrival of the Senators: Senators Chafee, Durenberger, Packwood, Wallop, Baucus and Daschle. And the questioning will be limited to five minutes because we have quite a number of witnesses this morning.

Let me get to your last statement there, Mr. Denning, because I think a very compelling case has been made already by the witnesses that much of the elderly's health payments are unprotected. Yet as I indicated at the outset, the practical realities may well be that the committee's agenda would be limited to just filling the most pressing of those gaps. Now with what you said in mind, would you rather have no bill, or would you rather have us do what we can do within the constraints of the budget that we face?

Mr. DENNING. Well, I think that we would want to do as much as we can, but I would also think that we would want to provide a package that would cover some essentials. And, of course, I think you realize that our older people are "willing to pay", but if we have something that really covers some of their needs. Then I think you would find the attitude positive.

The CHAIRMAN. All right. Now you said "willing to pay".

Mr. DENNING. Yes.

The CHAIRMAN. And I listened to Professor Cohen talking about the elderly not paying, and letting those that were younger and earning carry that burden.

Where do you come down on that?

Mr. DENNING. Well, the Association has discussed the needs of, you know, not only the older people but the working people as well, and we certainly tend to feel that working people need to be considered in our plans for whatever we do, and that we need to consider their income and the burden on them as well.

Now I would say to you that if a plan is presented, and there is a package that has benefits that would tend to do some of the things we are talking about, then I think we would have to sit down and evaluate it, and decide what direction we go. And I think that is what you are trying to come up with now.

The CHAIRMAN. That is what we finally have to do here, isn't it?

Mr. DENNING. Yes.

The CHAIRMAN. Medicare's current package protects beneficiaries from the date they go into the hospital until 60 days after they leave the hospital or a skilled nursing facility. And during that period of time that patient pays only one deductible, but some of the benefits are limited. Now some of the critics would argue that the spell of illness concept is outmoded and very difficult to administer; yet, others note that it protects the patients from paying two $520.00 deductibles only a few weeks apart.

Under the Administration's plan, that spell of illness is eliminated and requires the patient to pay approximately $700 million in additional deductibles.

And I will ask this question of any one of you. Do you think that that spell of illness should be eliminated or should it be retained? Or if not, should patients have to pay no more than one deductible annually?

Professor COHEN. Well, my answer would be, in the order of priority and simplicity, I would have only one deductible a year on an annual basis. But I am also prepared, since I helped put the spell of illness in the bill, I am ready now to abandon it as I am to abandon several other things that are in the legislation, because we have had 20 years of experience, and I think now we could go to a year of coverage both for the deductible, both for the maximum payment, and both for the determination of the hospital period plus post-hospital period provided that you abolish the 3-day rule with regard to nursing home care.

The CHAIRMAN. Thank you.

Once again, I caution my colleagues to please observe the 5-minute limitation. Now the next Senator is Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman.

Mr. Cohen, as I understand your presentation, you would reduce the premium that is suggested by Dr. Bowen and you would increase the so-called Medicare tax that the individual workers pay.

Professor COHEN. Yes, sir.

Could I just elaborate a bit on that?

Senator CHAFEE. Well, not too long.

Professor COHEN. Okay.

Senator CHAFEE. I mean, we are under time limitations. I am glad to hear you, but brevity is of the essence.

Professor COHEN. Yes.

My point is that you could increase the maximum taxable earnings base, which is now $43,000 in Social Security, up to $50,000, thus taxing higher income people, making it less regressive, reallocating the 1.45 percent tax on Part B to equal or to raise it to the amount that you raise by the $50,000, and you would be able to probably get away and not have the $4.92 at all on the beneficiary. And you could probably, if you want to up that a little bit more, you could even expand the benefits like I have proposed in the bill.

Senator CHAFEE. Now see if I understand it. You would increase the taxable wages from whatever it is, 43 to 50.

Professor COHEN. Yes, sir.

Senator CHAFEE. And what would happen?

Professor COHEN. That increased income of X, I would then reallocate in the law the 7.15 percent of taxable income that the individual now pays. 1.45 of that goes to Medicare.

Senator CHAFEE. Right.

Professor COHEN. I would up the 1.45 to, let's say, 1.5, to 1.55, whatever it turns out, that is equivalent to the increase in income that came into the total system.

Senator CHAFEE. You would only apply that. That increased premium would not apply to the workers as a whole.

Professor COHEN. Yes, sir.

Senator CHAFEE. It would apply to only——

Professor COHEN. No, sir. I would apply it to everybody that is taxable under the 7.15 percent, yes, sir.

Senator CHAFEE. Oh, so somebody working for $8,000 a year would have his premium go up, his Medicare premium.

Professor COHEN. Only for persons only covered for Medicare. It would not be a burden on the poor. It would not be a burden on the people who are retired. It would be a burden on the more upper income groups, including myself and other people, who are providing for the money.

Senator CHAFEE. Well, I must say I am confused. The increased premium that you suggest would go to all workers or just those who got to above $43,000?

Professor COHEN. Oh, just above the $43,000. Yes, sir. There would be a $7,000 increase of income on employers and employees which would produce millions of dollars, which would permit you to readjust the Medicare rate for the income that you decided were needed for the additional new benefits.

Senator CHAFEE. All right. Thank you.

Now, I don't want to cut you off, but we have got a very stern chairman here whose gavel is poised.

Mr. Denning and Mr. Hutton, in both your testimonies you noted the difficulty that low income elderly individuals have in purchasing Medigap. In other words, the poorest people who need it cannot afford it, so, therefore, do not have it. Now what do you think about allowing the States the option of covering elderly individuals below 200 percent of the poverty level, those States having either a fully or an income adjusted premium for some type of insurance? What do you think of that?

Mr. HUTTON. Well, how would you expect the States to operate that? You mean by giving them proxies?

Senator CHAFEE. Well, I have got a suggestion involving a purchase of a Medicaid premium.

Mr. HUTTON. I hope it would not be the same kind of Medigap insurance that we have in most of the private efforts.

Senator CHAFEE. Well, as I said, it would be an income adjusted premium. In other words, it varied according to what the people can afford. And obviously it would be low enough.

Mr. HUTTON. That would be acceptable.

Mr. DENNING. We are definitely concerned about the Medicaid standards on the State level because they vary so much. We think they should be standardized. And probably what you are saying here is one way of reaching some standard, giving them the opportunity to do so. I think we would have to give it a lot of consideration.

Senator CHAFEE. Yes.

Now, finally, a quick question. We all recognize that Secretary Bowen's proposal isn't the ultimate. If you had your druthers, would you accept—and we are just starting, and we are going to have that premium of $4.92—would you rather have it used for something else than how he proposes to use it?

Mr. HUTTON. Yes, I would. We think the first demand for older people would be for a prescription drug program.

Senator CHAFEE. In other words, you wouldn't go to the extended hospital care coverage.

Mr. HUTTON. Not yet. I would like to think that we could reach that in the not too distant future.

Senator CHAFEE. But your first priority would be the drugs.

Mr. HUTTON. And then a provision for the spouse not being forced into poverty when her husband has to go into a nursing home. That is a Medicaid matter though.

Mr. DENNING. I think you are recognizing that he is recognizing where some of the real problems lie. And I think all of us are concerned about meeting the needs of those people that have the real problems because you are talking about a very few people on the other side, and they are way down the line, from help.

The CHAIRMAN. Thank you very much, gentlemen.

Senator CHAFEE. Thank you.

The CHAIRMAN. Senator Durenberger.

Senator DURENBERGER. Thank you, Mr. Chairman.

Since I have got to minority status I have been trying to figure out what to do with my time. [Laughter.]

And there never was a problem in the majority because there was always plenty to do. So my questions, I like priority kinds of questions. If I want to continue to commit on this committee, and particularly my time, to improving access to in the quality of health care for elderly and disabled Americans. Is this the subject we should be on, in your opinion? Is catastrophic the number one priority that we ought to be spending our time on now? It sort of looks like we have made it a number one priority because most of us agree we ought to do something about it. Is that the number one thing we ought to be putting our effort into?

Mr. DENNING. I believe, according to the survey, long-term care comes up in the first bracket.

Senator DURENBERGER. And where is catastrophic then?

Mr. DENNING. Well, catastrophic is connected with it, but we are talking about something of great importance on nursing, as we mentioned here, the drugs, the skilled nursing facilities, spousal impoverishment, and some of the gaps in Medicaid.

Senator DURENBERGER. Well, AARP says long-term care first and then acute care catastrophic?

Mr. DENNING. We have included health care. And long-term care is one of the major concerns, and, of course, catastrophic care is tied to it.

Senator DURENBERGER. All right.

Mr. HUTTON. Well, the trouble, Senator, has been, for example, that the so-called catastrophic health care program, which has been produced by the Secretary of HHS and supported now by the President, does not cover catastrophic care at all. It only adds to the confusion of people who do not really now know what Medicare covers. And it certainly doesn't cover heart disease. It doesn't cover cancer. It doesn't cover Alzheimer disease. None of the real catastrophic illnesses are covered in this program.

Senator DURENBERGER. I don't want to debate you on that one. You are wrong, but I don't want to debate you on that.

Mr. HUTTON. All right. [Laughter.]

That is a great way to win, Senator. [Laughter.]

Senator DURENBERGER. Well, you are somewhere between acute care and chronic in what you say. We haven't covered chronic illness.

Mr. HUTTON. It looks to me like the committee is desparately concerned about the lack of money. We have got to pay so much money towards the deficit, that we don't know how we can finance the real health care problems which we have before us.

Senator DURENBERGER. Well, I am not coming from that direction. I am trying to get the most efficient use of the money we are now spending, which is why I started with catastrophic, because you and my parents and everybody else are wasting billions of dollars trying to get to catastrophic, and we haven't even defined what it is. That is why I am asking you the question.

Mr. HUTTON. Well, we did enact 22 years ago a Medicare program. Mr. Cohen will answer on that one. And I tell you we haven't done a thing to improve it in 20 years and that is a disgrace to any Administration.

Senator DURENBERGER. But now we are trying to start. And I am trying to ask you where is the best place to start? Wilbur?

Professor COHEN. Well, I approach it quite differently. I think this is the historic moment when another Administration has recognized the value and work ability of this program. I would even take Secretary Bowen's plan if I could get nothing else because it recognizes the importance of this program on a bipartisan basis. But then in the order of priority, I would like to say this. I am very conscious that the Social Security Administration and HCFA are not prepared to implement administratively this year all of the things that I would like to see.

They are in a shambles in the administration of the existing programs.

Senator DURENBERGER. All right. Number one, two, three.

Professor COHEN. So my number one is extend long-term care that is already in the bill by knocking out the word "skilled", put in "nursing home care," which I think for another, roughly, 83 days, which would make six months, and experiment with that. Ask the Office of Technology Assessment to make a report to you within two years as to how that works so that you can go on in the next step to long-term care which, as Senator Bentsen says, including all the members of the Cabinet, thought that that was in the program.

Senator DURENBERGER. All right.

What is number two?

Professor COHEN. Number two would be to take the 10 or 15 leading prescription drugs and provide a deductible. Experiment with that. Recognizing that that is not the final answer. But give us demonstration of these two things, some nursing home care and some prescription drugs. I think inevitably Congress is going to have to do that.

Senator DURENBERGER. Have you looked at what we have done in the so-called Republican catastrophic——

Professor COHEN. No, sir.

Senator DURENBERGER. It is sort of a start in that direction.

Professor COHEN. Yes. I haven't had a chance to study it. I am sorry. I will do so.

Senator DURENBERGER. Anybody on the issue of drugs, have you looked at that part?

Mr. DENNING. I haven't seen it yet.

Senator DURENBERGER. All right.

Professor COHEN. Incidentally, just to make the point, if you go back to my report about 22 years ago, I recommended coverage of prescription drugs then when I was Secretary of HEW and I am still for it as a leading priority. But I don't want to do it all at once because I don't think we are administratively equipped to do it all today.

I want to say one other thing, Senator. Whenever you make this—whatever you make effective, do two things. Give enough lead time to make it successful, and, second, start it in the summer and not on January 1 when you have got all the flu and everything else. [Laughter.]

The CHAIRMAN. That sounds like pretty sound advice.

Professor COHEN. That is the greatest thing that I put in Medicare in 1965, to make it effective July 1 when all the doctors wanted to take their July 4th vacation. It started out successfully.

The CHAIRMAN. Thank you very much, gentlemen.

Mr. DENNING. I think it really should be said that the Administration's plan——

The CHAIRMAN. I will have to ask you to hold it to the five minutes. Senator Baucus.

Senator BAUCUS. Thank you, Mr. Chairman.

Professor Cohen, I am curious about a refinement of your proposal to lower the monthly premium from $4.92 to $2.00, and I take it from your discussion with Senator Chafee you would raise the base from $43,000 to $50,000, whatever it is. Would that increase in taxable income be applied to only hospital insurance or would it be applied to the whole——

Professor COHEN. No, sir. Let's see. It is a little complicated. I want to yield enough money from the raising of the maximum wage base that would pay entirely for whatever the Senate Finance Committee votes on benefit improvements. It would be budget neutral.

Assume for the moment that that would yield X million dollars, and that hundred percent, with indexing, finances this program in perpetuity without any further general revenue. Then ask the actuaries to revise the 1.45 allocation in the 7.15 to the extent that is necessary to finance all these Medicare programs without costing any more money.

Senator BAUCUS. Then would you lower the Social Security portion?

Professor COHEN. Yes, sir. You could keep the Social Security portion exactly where it is.

Senator BAUCUS. Leave that where it is.

Professor COHEN. Although the allocation in percentage may change out of the 7.5——

Senator BAUCUS. Because you have raised the 1.45 to whatever it takes.

Professor COHEN. Yes, sir.

Senator BAUCUS. And would that apply both to employees and employers?

Professor COHEN. Yes, sir.

Senator BAUCUS. Equally.

Professor COHEN. It makes it more progressive. It puts a greater burden on the higher income people. And let me tell you why that is very logical. Medicare benefits are the same for everybody in the United States. And I believe, although we were not able to put this in 1965, that I ought to pay somewhat more for the premium than a lower income person. As a matter of fact, I have no objection to even taxing that proportion of Part B, which is the federal revenue portion, that is, three-quarters of the Part B premium. That is a free gratuity to me. I get that. That is about $60.00 a month I am getting, and my wife is getting totalling $120.00 a month free, nontaxable benefit.

So if you want to raise more money, that is another way of doing it.

Senator BAUCUS. That is an interesting idea.

Do you have any idea how much higher the 1.45 would have to be?

Professor COHEN. No, sir. I would go to—depending on what your benefits were when you looked at it. I would go at least to, oh, 1.5, and I think you could go even somewhat higher. And, if necessary, I would go to $60,000 for the maximum wage base. In other words, after you gentlemen have decided what you think is the logic of the benefits that ought to be done now in the package, I would have CBO price it out in terms of this kind of financing. And I think then you could take a look at it.

Senator BAUCUS. I think it is a good idea, frankly. Thank you very much. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, gentlemen. Senator Daschle.

Senator DASHCHLE. Thank you, Mr. Chairman. I would like to continue on with some of the questions that we have already had about priorities, because I think they have been very good ones.

As I understand it thus far, you seem to share a uninimity of view with regard to the priorities, that prescriptive drugs, that long-term nursing home care, ought to be either ahead of or at least on an equal part with Secretary Bowen's proposal. Is that correct?

Mr. HUTTON. Yes.

Professor COHEN. I think that is correct. Let me say, I would be a little conservative and cautious in what you do this year to not go the whole way because I don't think we are prepared administratively to do that. If you want to talk about that, I could tell you why. But then I would put the Office of Technology Assessment into looking at the long-range cost of that, so you would be on a conservative basis. And then see in two or four years how to finance it to expand it.

Senator DASCHLE. I assume, do I not, that you would set the same guidelines with regard to eligibility? You are extending the benefit, but the eligibility criteria that Secretary Bowen is suggesting are ones that you would subscribe to?

Professor COHEN. I am not quite sure what you mean on the eligibility.

Senator BAUCUS. Over the age of 65.

Professor COHEN. Oh, yes. Plus the disabled, sir. Don't forget them.

Senator DASCHLE. So you would include the disabled.

Professor COHEN. Oh, I would include the disabled in it because their costs are really three or four times even the aged costs. I wouldn't leave out the disabled or the kidney dialysis and renal transplant coverage, which is in the law too. No, sir.

Senator DASCHLE. So you are including Secretary Bowen's proposal for all disabled and all elderly, in addition to prescriptive drugs and long-term nursing care?

Professor COHEN. Of course, when you say that I have to raise my third priority point, and that is to lower that disability insurance eligibility for medicare from 24 months to six months. I think that making those disabled people wait 18 months more before Medicare is available is not the most socially desirable thing to have done when we did it. We had to do it because of financial considerations in 1972.

Senator DASCHLE. Aren't you getting to a point where even those who are in Fortune 500 are going to be concerned about the bill here?

Professor COHEN. Yes, sir.

Senator DASCHLE. If you raised the maximum wage base, just eliminated it entirely, is it your view that you could pay for all that you are suggesting?

Professor COHEN. Let me say, first, don't forget the maximum wage base is going to go up by law anyway. It goes up indexed to the increase in wages. So you are going to get to 50, or 60, or 70 thousand dollars in due time, depending on inflation and so on.

All I am saying is advance that a little ahead of time to meet the cost of whatever you gentlemen want to do.

Senator DASCHLE. It is a legitimate proposal. I am just wondering whether or not what you are advocating, which I am not adverse to—I think it makes a great deal of sense—the question as has been asked in many forms already this morning is, how does one pay for it? And what your suggestion is—and I would be interested if you could somehow substantiate your argument—that simply by raising the maximum wage base we have accomplished all that we need to accomplish with regard to financing. Have there studies that have been done?

Professor COHEN. No, sir.

Senator DASCHLE. This is just a guess then?

Professor COHEN. Yes. But let me say this. I have been before this committee on financing on innumerable times. Every way has some serious disadvantage. But I know that you are faced with the point that Senator Bentsen said, "if you are going to improve the benefits, I want somebody to pay for them." There is no free lunch. I don't believe that we ought to go into this without recognizing there are tremendously increased costs.

Gentlemen, in the year 2000, Medicare costs in this country are going to be closer to 13 percent of GNP than 10.6 at the present time. You have got to take into account that these costs are going up for an indefinite period of time because of the aging of the population, and technology of medical care.

So we have got to educate people that they have got to pay for it.

Senator DASCHLE. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Daschle, we have the Joint Tax Committee costing out this kind of an approach. This is one of the options that we are considering. Senator Mitchell.

Senator MITCHELL. Thank you, Mr. Chairman.

Everyone recognizes, and you have emphasized, that the Secretary's plan which deals merely with defining "catastrophy" solely with respect to acute care cost is only a minor part of the problem, less than 20 percent, and that 80 percent of the total cost comes from the long-term care problem.

I am now in the process of drafting legislation to try to deal with that, and I welcome your ideas. Really, it is a problem of redistributing costs. It is the classic insurance problem. A few people, relatively speaking, have enormous costs. A much larger number of people have much lower costs. And you and I want to redistribute it in a manner that the group bears the burden as opposed to individuals or families. That is the task.

Now, paying for it is the problem. I believe it can be done by a combination of things, one element of which would be to ask the participants, the elderly themselves, to share in the burden. That is done now in the form of a premium. Dr. Bowen suggests $4.92 will pay for the acute care cost. To establish a premium for long-term care would be difficult on the current data base, and it would probably be prohibitive for the very people who need it most.

My question is, do you think the elderly who you represent and who you say regard long term care as an important problem would be willing to share in the burden of redistribution, for example, in the form of an income tax surcharge?

Professor COHEN. I happen to personally favor an income tax surcharge on the amount, particularly of the, as I said, the gratuity that I receive as a beneficiary myself.

Senator MITCHELL. You are talking about the Stark bill.

Professor COHEN. No, sir. I am opposed to the original Stark-Gradison financing approach. My approach is different. I would take the three quarters of the Part B premium—let's say, just for sake of argument, that is $800.00 a year—and I would make that taxable income under the existing tax.

Senator MITCHELL. Subject to tax.

Professor COHEN. I would have a separate line though in the income tax saying Medicare tax, and if that is 38 percent for me of that $800.00, I think I ought to pay that as income.

Senator MITCHELL. What would your reaction be to, say, a 2 percent surcharge on persons over 65 on income to go toward the payment of a long-term care, Medicare Part C or something like that?

Professor COHEN. Yes, sir. I would favor that too.

Senator MITCHELL. Let me ask Mr. Hutton and Mr. Denning if they would favor that.

Mr. HUTTON. I would favor a limited surcharge rather than any other approach. I do think that we have got some income coming in. We should also cover State employees in Medicare. That would be additional funds coming in.

We are hoping that we will get some $2 billion coming into the system from the introduction of State employees to the system, which have been outside it, and yet benefit from the Medicare provisions.

Senator MITCHELL. Well, not all of them.

Mr. HUTTON. Not all of them.

Senator MITCHELL. But let me get Mr. Denning's reply. Would you favor a surcharge of this type?

Mr. DENNING. We have not surveyed our members in breaking it down, as you have suggested here, but we have talked to them and surveyed them relative to their willingness to pay. If there is a package that has the benefits that you are talking about here, they are willing to up the cost for it on some basis, progressive income financing or some method of that type.

Senator MITCHELL. Well, the cost is substantial, probably $16 billion a year. And so it would require a combination of financing. But you have got the problem of working people now who feel the burden is too heavy on them. And if you create a structure which adds another benefit, even though it is for their parents and they will someday be there, without requiring a contribution by those who are presently beneficiaries, politically it is not feasible.

Professor COHEN. Could I give you the justification for your position, which persuades me how right you are? I don't think it is going to be successful to have long-term care——

Senator MITCHELL. A kind of witness I like to hear. [Laughter.] Go ahead.

Professor COHEN. Senator Mitchell, I think that you are not going to be able in the next 20 years to get long-term care financed on a voluntary insurance basis by selling private policies.

Senator MITCHELL. But, you see, let me tell you something, Mr. COHEN.

Professor COHEN. You see, therefore, putting it on the income tax for people age 65 gives them all the coverage.

Senator MITCHELL. You can encourage private insurance in this field by dealing with one problem, uncertainty. The lack of insurance is based upon the fact that the insurors cannot possibly now know what the long-range costs will be. But if you establish a substantial deductible in point of time, and say that after eligibility is determined the benefit will commence at some defined point in the future, say, six months, you then establish all the insurors a period of time, and they will rush to fill that gap, and you will also significantly reduce the cost because——

Professor COHEN. Sure.

Senator MITCHELL. Of course, as you know, the number of persons entering who will remain six months or more, or three months or more, it declines very rapidly.

Professor COHEN. That is right.

The CHAIRMAN. Thank you very much, gentlemen. Senator Heinz. I know this line of questioning will be pursued because it is one that is pertinent to the whole issue.

Senator HEINZ. Thank you, Mr. Chairman.

What kind of revenue—Bill, Wilbur, any of you—would a 1 percent surcharge on the taxes of those 65 and over yield?

Professor COHEN. 1 percent. I don't know the exact figure. But if you told me what the yield of 1 or 2 percent was, I will give you the benefits that will be equal to that.

Senator HEINZ. Oh, I have no doubt——

[Laughter.]

Senator HEINZ [continuing]. Wilbur, that you could figure out a way to spend it. [Laughter.]

Professor COHEN. I couldn't resist it.

Senator HEINZ. I think I have already got a list, and an intriguing list it is.

Bill Hutton or, I don't recall, one of you said—I am not quite sure you meant exactly what you said or maybe I misheard—you said, "Including three-quarters of the Part B premium in income for those who benefit from it." I assume what you meant was that you were going to take the government-paid portion of the Part B premium.

Professor COHEN. That was the point I just made.

Senator HEINZ. The three-quarters that is not paid by the beneficiary.

Professor COHEN. That is correct.

Senator HEINZ. I thought you meant that. How much money does that raise if you do that?

Professor COHEN. I could not tell you right now. I don't have access to government actuary any more.

Senator HEINZ. I thought between the three of you you would have access everywhere. [Laughter.]

John Denning, do you favor the financing mechanisms that your two colleagues have proposed if they were applied exclusively to increases in benefits of the type we have described?

Mr. DENNING. I think they have brought up some very good points, and they certainly do fit in the categories that we have been discussing. We have, of course, in the plan that we presented to you, you will note, we also suggested a $10.00 premium fee as long as it didn't reduce the Social Security payment. So there are many ways to do it. But I think, first, we have to decide what we want to do and then find a financing system to do it.

Senator HEINZ. It may not work that way.

Mr. DENNING. It simply does not need to increase the deficit.

Senator HEINZ. Many of us know what we want to do. We just can't do it for all kinds of reasons. Our wife doesn't want us to. Our income doesn't permit us to. Our job doesn't permit us to. What I thought I heard all of you saying a minute ago is we have a real problem in this country today. We can talk until we are blue in the face about the need for long-term care assistance for nursing home and home health care, but the reality, whether we like it or not, is we have got to find out a way to pay for it.

Professor COHEN. I would accept Senator Mitchell's approach to this. As I said earlier before you came in, Senator Heinz, I would amend the present law to extend nursing home care for six months because, as Senator Mitchell says, a very large proportion of the people in nursing homes only stay about six months. Now the distribution is over four or five years. But why don't you take the first six months of nursing home care with a very substantial deductible. I suggested $10.00 a day, which is $300.00 a month. And now the reason I say $300.00 is don't forget a big change has been made. Everybody has got approximately three or four hundred dollars of Social Security in this group. Not everyone, but a lot of them.

Senator HEINZ. How many more people would seek nursing home institutionalization, do you think, if we did exactly as you said?

Professor COHEN. Well, I don't know. But I tell you what I would do, because you may be on the verge to this question, would there be a large number? I would take the provision out of Claude Pepper's bill where he has a geriatric evaluation of each individual, rather than merely having a single doctor certification to a nursing home. I think you ought to look at what Claude Pepper has written in his bill on that point. It is well worth doing. That would act as a control on this, but at the same time give you that six months of experience with a study as to what the long-term cost with that deductible that would permit private insurance to still sell the supplementary policy, put part of the burden on the aged in that way, but distribute part of it over his life time. That is a good overall compromise in my opinion.

Senator HEINZ. Thank you very much.

The CHAIRMAN. Thank you, gentlemen.

Senator HEINZ. My time is about to expire.

The CHAIRMAN. Senator Danforth, do you have any questions?

Senator DANFORTH. No, Mr. Chairman.

The CHAIRMAN. For the record, let me give you some numbers that I have been provided on the question that we have been dealing with. If you talk about the elimination of the cap on Medicare only, the unofficial—and I stress that, and it is CBO, not the Joint Tax Committee—estimate is that you would raise in fiscal year 1988 $2 billion; 1989, $7 billion; 1990, $7 billion; 1991, $7 billion; and 1992, $8 billion.

Now the Bowen plan, the estimates of the cost, are, in 1988, $1.46 billion; 1989, $2.4 billion; 1990, $3 billion; 1991, $3.6 billion. The Stark-Gradison plan would be $2.2 billion in 1988; $3.7 billion in 1989; and $4.5 billion in 1990. That gives you some idea of the parameters. But I must emphasize those are very unofficial figures put out by CBO.

Gentlemen, thank you very much for your testimony.

Senator CHAFEE. Mr. Chairman, can I just ask for one quick show of hands? What Dr. Cohen is suggesting here seems to me to be rather revolutionary, and I just want to make sure I understand it. What you were suggesting is that the government share of the Part B premium, which is 75 percent of whatever the premium is, be included as income, even though the person does not receive it, be included as income and then be taxable.

Professor Cohen. Yes, sir.

Senator CHAFEE. Do you, gentlemen, agree with this? Yes or no, Mr. Denning?

Mr. DENNING. Including that in income and taxable, we do support a related income program.

Senator CHAFEE. And, Mr. Hutton?

Mr. HUTTON. I do not at this stage. The Executive Committee is not meeting until next week. We are discussing it then.

Senator CHAFEE. All right. Thank you very much.

Mr. HUTTON. I would be glad to let you know, Senator.

Senator CHAFEE. Yes. I would be interested what the conclusion is. Thank you, Mr. Hutton.

The CHAIRMAN. Well, I thought that was an excellent panel and there were some good suggestions offered. The next panel will be John P. McDaniel, who is the president of Midlantic Health Care Group, on behalf of the American Hospital Association. If you will come forward, please, sir. Next Dr. Jerald R. Schenken, the board of trustees, American Medical Association, Omaha, Nebraska. Dr. Paul Willging, who is the executive director of the American Health Care Association. Dr. Ruth Constant, who is the president of the Port Arthur Home Health, Beaumont Home Health and Wichita Home Health, Victoria, Texas, on behalf of the National Association for Home Care.

Mr. McDaniel, if you would proceed, please.

STATEMENT OF JOHN P. MCDANIEL, PRESIDENT, MIDLANTIC HEALTH CARE GROUP, WASHINGTON, DC, ON BEHALF OF AMERICAN HOSPITAL ASSOCIATION

Mr. McDaniel. Thank you, Senator Bentsen, and members of the committee.

I am pleased to be invited here to speak with you today about the concerns with regard to our nation's health care financing mechanisms and the ever present risks associated with catastrophic illness.

The subject of this hearing, catastrophic illness, is of great concern, of course, to our senior citizens, to members of the general public, and to the American Hospital Association's 5600 health care institutions.

Catastrophic illness, from the economic perspective, primarily relates to, we view, three population groups. Broadly speaking, they include Medicare beneficiaries who incur catastrophic acute care expenses; number 2, Medicare and non-Medicare eligible persons who require, as a result of chronic illness, long-term care for which they have no insurance or financial protection; and, number 3, individuals and families who are underinsured and uninsured, as well as those who lack the means to pay for those health care expenses that they incur.

From the experience of a practicing health care executive and representing an organization based here in Washington that has several hospitals, I would like to share some of our experiences with real life situations that are occurring as we speak today in our hospitals here in Washington.

Example 1 is the Medicare beneficiary at the Washington Hospital Center who has catastrophic acute care problems, a 66-year-old patient, chronic patient, coronary bypass surgery, perforated ulcer, experiencing complications, trying hemodialysis, is respirator-dependent, and has been in the intensive care unit for 85 days. Total hospital charges as of today of $345,000.00. Medicare payments covered as of today of $60,000.00. Currently, as we speak, the patient's liability is over $100.00 a day and soon will expand to $200.00 a day; the hospital, of course, suffering the liability of the difference between the two.

Example 2, a hospital down the street, also a tragic case, a relatively young man, 40 years old, who was struck by a car on May 1 of this year, had no insurance, bilateral hip fracture, broken legs, head injuries, multiple organ problems, and on IV feeding tubes. We are having difficulty in finding an appropriate post-hospital setting for this patient as he is now ready for discharge. His cost, as of today, is approximately $450,000.00 in the way of charges. We anticipate receiving less than $70,000.00 from Medicaid, but then not until the patient is discharged. His life has clearly been shattered. He has no financial resources.

And, last, an example of a number of problems, approximately 20 patients in Capitol Hill Hospital, right down the street—you can practically see it from the steps of this building—20 patients who are awaiting discharge. No adequate placement can be found. They have no financial resources. These patients are totally indigent in that sense, and we are awaiting fiscal intermediary determination as to where they can go and how they are going to be taken care of, or whether they are going into their own homes, most of which are with families that have to assume the entire burden, not only of care giving but also of the financial consequences.

A few suggestions, very briefly, most of which have been covered earlier. But on behalf of the AHA, as well as our organization, we think that catastrophic coverage of Medicare beneficiaries should eliminate the limits of the coverage on acute inpatient care, expand the coverage for home health care and nursing home services, extend the coverage for prescription drugs, and replace the current cost-sharing requirements for Medicare patients and adopt an annual out-of-pocket expenditure limit.

To finance these provisions, a Medicare premium should be instituted paid by all beneficiaries, not just those in Part B.

To address the most common cause of catastrophic expenses——

The CHAIRMAN. If you would summarize, Mr. McDaniel.

Mr. MCDANIEL. It will be summarized in the testimony, sir, that has been submitted for the record. Thank you, sir.

The CHAIRMAN. Thank you. Dr. Constant.

[The prepared written statement of Mr. McDaniel follows:]

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STATEMENT
OF THE
AMERICAN HOSPITAL ASSOCIATION
BEFORE THE
COMMITTEE ON FINANCE
OF THE
UNITED STATES SENATE
ON
CATASTROPHIC COVERAGE

March 19, 1987

INTRODUCTION

Mr. Chairman, I am John P. McDaniel, President of Medlantic Healthcare Group, a regional, not-for-profit health care system based in Washington, D.C. The issue of catastrophic coverage is of great concern to the American Hospital Association's 5,600 member health care institutions. Over the past several years, the AHA has examined a number of alternatives for improving the Medicare benefit package, for making it more comprehensible to Medicare beneficiaries, and for ensuring the long-term fiscal soundness of the program. The AHA also has examined public- and private-sector alternatives for addressing the needs of the non-Medicare population who are medically indigent.

Last December, the AHA had the opportunity to present to another committee of Congress our recommendations for a comprehensive approach to catastrophic coverage, addressing needs of the elderly and non-elderly for acute and long-term care. The increased level of debate and interest that has occurred since then is heartening. Several bills have been introduced that address certain aspects of the catastrophic illness problem, including the Administration's proposal, S.592, introduced in the Senate by Senator Dole. You are to be commended for your willingness to address the multifaceted problem of providing desperately needed relief for Americans from the fear of catastrophic illness and expense.

We would like to take this opportunity to review the scope of the catastrophic illness problem and our recommendations for a comprehensive approach to its resolution, concluding with a few comments on the Administration's proposal.

DIMENSIONS OF CATASTROPHIC ILLNESS

Each year, thousands of families face financial ruin because one of their members incurs health care expenses that are not covered by insurance and are beyond the family's ability to pay. When this happens, a serious illness --which can be a personal catastrophe--becomes a financial catastrophe for the entire family. Most Americans are protected against the cost of acute medical care through either private insurance, Medicare, or Medicaid. But, 37 million Americans face financial catastrophe from serious illness because they lack any form of insurance. An estimated 20 million of the non-Medicare insured population also may be at risk for catastrophic acute care because of limitations on private insurance coverage. Even in the Medicare population, a substantial amount of acute care must be paid out of pocket because of limitations on Medicare coverage.

Catastrophic expenses result from three gaps in health insurance coverage: inadequate Medicare coverage of catastrophic acute care costs; even more inadequate public and private coverage of long-term care costs; and the presence of large numbers of uninsured and underinsured in the non-Medicare population.

As currently structured, Medicare does not provide catastrophic coverage, even for acute care. Acute inpatient hospital care can cause significant out-of-pocket expenditures for a small percentage of beneficiaries. For example, a patient staying in the hospital 60 days incurs an inpatient deductible of $520, plus 20 percent of any physician charges. The copayment totals $4,200 after 90 days and $18,942 after 150 days. This does not happen very often: in any given year only 20-25 percent of Medicare beneficiaries require inpatient care, and less than 1 percent of those hospitalized in an acute general hospital stay more than 60 days. In 1984, beneficiaries incurred about $4.8 billion dollars in first-day deductibles--accounting for 98 percent of all copayments and deductibles for general hospital acute care admissions. When Part A and Part B services are considered, it has been estimated that about 8 percent of enrollees owed coinsurance and deductibles in excess $1,024 in 1984. It should be noted, however, that new delivery patterns emphasizing outpatient care are creating new gaps between patient expenses and Medicare coverage and, therefore, new patterns of catastrophic expense.

Although the incidence of acute catastrophic care expense may be small, most Medicare beneficiaries may perceive themselves to be "at risk" because catastrophic expenditures are difficult to predict, and Medicare coverage rules are hard to understand. Most Medicare beneficiaries purchase supplemental or "wrap-around" coverage, perhaps perceiving it as protection against catastrophic acute care expenses or possibly as protection against long-term care costs as well. But, "wrap-around" coverage benefits are limited to Medicare-covered services, which means that even with "wrap-around" policies, most Medicare beneficiaries still run the risk of incurring catastrophic out-of-pocket acute care expenses and have almost no protection against long-term care costs.

Outpatient pharmaceuticals are another significant and growing source of out-of-pocket expenditures for the elderly, with only about 20 percent of such costs covered by any form of insurance. As more care shifts to non-institutional settings where Medicare does not cover prescription drugs, out-of-pocket expenses are increasing. Many beneficiaries find themselves choosing between spending limited resources on needed drugs or on the basic necessities of food and shelter.

Another obvious gap in the Medicare program is catastrophic coverage for the treatment of mental illness. Although approximately one-fifth of the Medicare population should have such treatment (the American Psychiatric Association estimates), those with mental health problems are subject to a 50/50 copayment, and Medicare will pay no more than $250 for outpatient care of mental or emotional disorders. Those with acute mental illnesses--episodic or chronic--require services on a recurrent or continuing basis.

Gaps in insurance coverage also exist for patients needing medical rehabilitation, whether it is the Medicare beneficiary recovering from a stroke or a young accident victim requiring extensive occupational and physical therapy.

Among Medicare beneficiaries, the leading cause of catastrophic expense is long-term care associated with chronic illness. Medicare provides little coverage for institutional long-term care, consistent with its focus on covering the cost of acute medical episodes. More than 90 percent of expenditures for long-term care now come from two sources: out-of-pocket expenditures and Medicaid. Out-of-pocket expenditures by consumers account for about 45 percent of all long-term care expenditures. Among elderly families spending more than $2,000 in a year for medical care, 81.2 percent of the expenses are for nursing home care, compared with only 10 percent for hospital care and 5.9 percent for physician care. As a result, almost half of the 75-year-olds who enter private nursing homes are bankrupt in 13 weeks, and more than 70 percent exhaust their resources after a year. Once these catastrophic expenditures have been made, the elderly can obtain catastrophic coverage from Medicaid, but by that time the illness will have impoverished any non-institutionalized spouse or dependent, and thereby pushed more people into a state of public dependency.

This use of Medicaid as the payer of last resort for long-term care has absorbed a large and increasing proportion of Medicaid funds and put considerable pressure on funds available to support the non-Medicare poverty population. Currently, about three-fourths of all Medicaid expenditures are used to pay long-term care costs and other expenses generated by Medicare enrollees, leaving about one-fourth for the growing number of non-elderly, non-disabled poor. This conversion of Medicaid into a supplemental policy for Medicare enrollees exacerbates the third catastrophic care problem: the presence of a large and growing number of uninsured and underinsured non-elderly. For those without insurance, any significant illness is generally catastrophic, and the number of uninsured is growing. By 1985, 37 million people lacked insurance, one-third of them living below the poverty level and another third below double the poverty level. This large and growing number of uninsured results from two trends: an increase in the number of people below the federal poverty level, and a simultaneous decrease in the number of people covered by Medicaid. By 1983, Medicaid covered less than 40 percent of the poor, compared with 65 percent in 1976. For the uninsured, the most frequent cause of catastrophic illness is acute care, and even moderate expenses can be catastrophic.

The absence of insurance coverage for non-catastrophic acute care may actually increase the likelihood of catastrophic illness. For example, many studies have shown that lack of prenatal care, a frequent occurrence among the uninsured, results in high-risk births and often very high neonatal intensive care costs. In addition, of those who are insured, a significant minority--especially those with individual rather than group coverage--still run a significant risk of incurring medical bills they cannot pay, and therefore are "underinsured" for catastrophic care. One study found that about one-fourth of the non-elderly population--more than 57 million people in 1985--is either uninsured or underinsured. Although much of the discussion regarding catastrophic health insurance has focused on the elderly population, children and their families also suffer from the effects of catastrophic illness. Although Medicaid covers poor children, benefits vary widely from state to state. It is estimated that 12 million children under the age of 18 are uninsured. And even for families with insurance, a traumatic childhood illness or a serious chronic disease or disorder could result in financial catastrophe for the family, either through increased out-of-pocket expenses or wages lost because of time spent with an ill child.

In a sense, uncompensated care costs represent a second stage of catastrophic care costs, after a person or family can no longer pay out-of-pocket for uncovered care. In 1985, uncompensated care (charity care and bad debt) provided by hospitals to those unable to pay cost hospitals--and, indirectly, other hospital patients--$7.4 billion. This was more than double the cost in 1980. Given the current conscientious debt-collection efforts made by hospitals, this $7.4 billion represents costs that patients could not pay, i.e., clearly catastrophic costs.

In short, while discussions of the catastrophic care problem frequently focus on the dramatic, relatively rare, acute care expenses of the elderly, the catastrophic care problem is much broader and much deeper, extending to both young and old, uninsured and insured.

TOWARD A COMPREHENSIVE SOLUTION

Any comprehensive solution to the problem of catastrophic illness must address the three gaps in health insurance coverage: (1) inadequate Medicare coverage of catastrophic acute care costs, (2) even more inadequate public and private coverage of long term care costs, and (3) the presence of large numbers of uninsured and underinsured in the non-Medicare population. The AHA's recommendations fall into these three areas.

Medicare Catastrophic Acute Care

For Medicare beneficiaries, major issues include the fear of future insolvency and collapse of the program, and an acute care benefit that covers less and less of their expenses.

Long-term Solvency of Medicare. Although improved in recent years, the financial outlook of the Medicare program remains cloudy. The declining ratio of workers to beneficiaries will contribute to long-term financial instability in the Medicare program and may place a severe burden on future generations of workers. Consequently, some have suggested the imposition of a means test to limit the size of the eligible population and to reduce future expenditures. Such proposals should be rejected. Universal coverage creates a strong base of political support for the program and spreads risk across the entire population. Also, many of the non-poor elderly and disabled would have major difficulties obtaining adequate private coverage, and most non-poor elderly would quickly become medically indigent if they suffered a catastrophic illness.

Medicare should continue to provide universal coverage for the elderly and disabled. Eligibility should not be tied to beneficiary income, but should be tied to the age of eligibility for Social Security benefits. Basic Medicare benefits should continue to be funded on a pay-as-you-go basis. To address the actuarial problems anticipated as a result of the changing demographic structure of the United States, and to fund acute care catastrophic coverage, Medicare should institute a premium, which should be included in out-of-pocket costs when comparing individual expenditures to an annual out-of-pocket limit. Through Medicaid, Medicare should pay the Medicare premium and provide supplemental coverage of required coinsurance for Medicare beneficiaries receiving or eligible for supplemental security income (SSI).

Restructuring the Benefit. The original Medicare benefit was structured around the belief that most acute care occurred in inpatient hospital settings. This is no longer entirely true. Services that are not covered at all by Medicare, such as prescription drugs provided to non-inpatients, have become an increasingly important part of medical expenditures of the elderly. The principal barrier to coverage of prescription pharmaceuticals has been the fear of substantial utilization and cost increases resulting from coverage for beneficiaries who use small amounts of services or for whom the costs of such services are a small percentage of income. These problems can be reduced by expanding the set of covered services to include prescription pharmaceuticals, but limiting that coverage with an annual deductible and copayments until an annual out-of-pocket limit is reached.

A more significant problem results from the increased reliance on alternatives to inpatient hospital care. Expenditures for outpatient services have risen as care has moved from the inpatient setting to the outpatient setting--for example, in the substitution of outpatient for inpatient surgery. Out-of-pocket expenditures have been increasing as a result because outpatient services more often carry copayment requirements.

A second source of increased out-of-pocket expenditures has been for covered skilled nursing facility (SNF) care. The current copayment level virtually eliminates the SNF benefit for all but the first 20 days. Medicare limits on the average daily routine cost allowed for SNF care, which vary by area and type of facility, range from $60 to $90. Because the current copayment is a set $65, Medicare only pays from zero to about 25 percent of the cost for days 21 through 100.

A third source of increased out-of-pocket expenditures is skilled nursing and home health services for which Medicare coverage is denied. Medicare beneficiaries are often caught up in the patent absurdity of being told they are not sick enough to warrant admission to a hospital, but they are too sick to be treated at home, and they cannot be treated in a SNF because they have not met the three-day prior hospitalization rule. Medicare administrators have used the absence of clearly defined coverage criteria to apply increasingly stringent medical criteria to skilled nursing and home health claims, resulting not only in the denial of coverage but also increasing reluctance on the part of some providers to accept Medicare patients.

The most pressing need is to require that medical review criteria used by fiscal intermediaries be written and made available to providers and beneficiaries to promote understanding of the benefit and better assessments of the appropriateness of claims denials for home care and skilled nursing care. Making some sense of coverage criteria for these services also should focus on a sorting out of where beneficiaries should be cared for when they have an acute episode of illness, and on providing the flexibility to use the appropriate level service without artificial barriers. In the course of doing so, it will be important to establish more appropriate conditions under which the services will be covered, including: relaxation of the "home-bound" and "intermittent care" requirements for covered home health care; elimination, in whole or in part, of the three-day prior hospitalization requirement for receipt of SNF care; and elimination of arbitrary barriers to the provision of and payment for needed skilled subacute services by qualified hospitals when extended care services are needed but appropriate placement is unavailable.

Even with Medicare's focus on acute inpatient care, some beneficiaries experience catastrophic expenses for their in-hospital care. Beneficiaries who exhaust the "basic" inpatient benefit of 60 days can rapidly incur copayments amounting to several thousand dollars, and each year a small, but significant, number of beneficiaries exhaust their "lifetime reserve" coverage of acute inpatient services. For these individuals, and for those beneficiaries who experience multiple hospital admissions in a single year, out-of-pocket expenditures can be substantial.

In addition, beneficiaries often have trouble understanding when their care will be covered. The use of "benefit periods" or "spells of illness" to determine if an inpatient stay is covered is confusing. Eliminating the limits on inpatient coverage would both provide coverage of catastrophic hospital stays and would make the Medicare benefit less confusing to beneficiaries. Further, the pattern of copayment varies by type of service, leaving beneficiaries uncertain as to their out-of-pocket obligations. An annual deductible for all covered services, combined with uniform copayment up to a maximum out-of-pocket limit keyed to income, would establish positive consumer incentives and protect all beneficiaries against catastrophic costs. An SSI supplemental package would protect access for low-income beneficiaries.

To address catastrophic acute care expenses resulting from inadequacies in the current Medicare benefit package, several changes should be made:

- Unlimited inpatient hospital care should be covered by eliminating all current limits;
- Coverage should be extended to prescription pharmaceuticals; and
- The restrictions on coverage of home health and skilled nursing services should be revised to permit beneficiaries to make use of less expensive alternatives to inpatient acute or long-term care, e.g., by relaxing the intermittent care and home-bound requirements for home health services and the three-day prior hospitalization requirement for SNF services.

The current system of copayment should be replaced by requirements that establish positive consumer incentives, that are sensitive to differences in beneficiary income, and that are more understandable to beneficiaries:

- Combined Part A and Part B expenditures for covered services should exceed an annual deductible before Medicare begins to provide coverage;
- After the annual deductible has been satisfied, a uniform percentage copayment should be applied to all covered services, subject to an annual out-of-pocket limit;
- Once the annual out-of-pocket limit is reached, no additional copayment should be required; and
- The annual out-of-pocket limit should vary with beneficiary income.

Supplemental insurance for required copayments and non-covered services should continue to be available through private insurers. As an alternative to private supplemental insurance, Medicare could offer a voluntary supplemental coverage option that would reduce required annual out-of-pocket expenditures. This coverage could be paid for through a premium equal to the actuarial value of the coverage, and would not be subsidized by tax appropriations to avoid preempting the private insurance market.

Also, the creation of tax incentives to allow Individual Medical Accounts (IMAs) should be considered as a means of encouraging Medicare beneficiaries to accumulate sufficient savings for future medical care costs, including the purchase of supplemental coverage, payment of the Medicare premium and copayment amounts, purchase of private long-term care insurance, or payment for long-term care. While IMAs cannot serve as a cornerstone for financing Medicare, they may reduce the future need to use general revenues or payroll taxes to fund care, particularly long-term care.

Offering beneficiaries the option of enrolling in qualified private health plans, which combine the financing and delivery of care and are paid on a capitation basis, also has potential as a means of providing catastrophic coverage at lower total costs to the program and beneficiaries. The expansion of these alternatives may be limited in the short term by the absence of actuarially sound methods of computing premiums or voucher amounts for individuals and small groups. Medicare should continue research and demonstration activities needed to develop and test methods of implementing a capitation option more widely.

Long-Term Care for the Medicare Population

Long-term care is the leading cause of catastrophic medical expenses among the elderly. Out-of-pocket expenditures by patients and their families are the most important source of financing for long-term care. Medicare covers only limited, post-acute skilled nursing care, while Medicaid covers long-term care at the skilled nursing, intermediate, and custodial levels. To qualify for Medicaid coverage, it is necessary to spend down savings and investments, including investments in a family home. Thus, to qualify for public assistance, it is necessary to incur catastrophic expenses.

The financing of long-term care (including skilled nursing facility, intermediate care facility, home care, and custodial "nursing home" care) has been, and will continue to be, a shared responsibility of individuals, the private sector, and state and federal government. The goals of public policy should be: to encourage individuals to make provision for long-term care needs to the extent permitted by their income; to provide access to needed long-term care when individual resources are inadequate; and to establish a more humane alternative to spend-down requirements. To attain these goals, we believe that:

- The development of private sector alternatives for financing long-term care should be encouraged through tax incentives and demonstration projects supported by both the public and private sector. IMAs might be structured as a type of long-term care insurance. These initiatives should include efforts to increase understanding among the elderly and non-elderly of the need for and cost of long-term care;

- For the population dependent upon public assistance, public programs should stress keeping patients out of institutional settings, when appropriate, and should encourage innovation in the delivery of care to the chronically ill. The restructuring of Medicaid and creation of a distinct program of long-term care coverage for low-income Medicare beneficiaries would encourage such innovation; and

- To protect the dependents of chronically ill individuals, and to reduce the risk of long-term dependency by those needing limited amounts of long-term care, a federal and state program of loans could be established through which a family could "borrow" against a beneficiary's estate to meet the cost of long-term care (including skilled nursing, intermediate, and custodial care) for an institutionalized family member. In the case of couples, the non-institutionalized spouse would retain the use of the assets until his or her death.

In the long term, it appears that the system of financing long-term care will continue to involve both the public and private sectors, although current public and private arrangements leave room for substantial improvement. More work is needed to develop innovative approaches in both the public and private sector, and to identify how best to meet the varying needs of different populations. Proposals such as the IMA, if combined with long-term care insurance, offer a potential means of encouraging the development of a more rational private system for financing some long-term care. Proposals to restructure Medicaid offer a potential means of making better use of public funds to care for those unable to finance their own care. And the proposed construction of a "loan" program provides a more dignified, and possibly cost-effective, alternative to Medicaid spend-down requirements.

Catastrophic Illness and the Non-Medicare Population

Concern over the problem of catastrophic illness among the Medicare population should not draw attention away from the significant problem of medical indigence in the non-Medicare population. Among the population not covered by Medicare, the major cause of catastrophic expense is acute medical care. Any significant illness is "catastrophic" for an individual without health insurance. Approximately 37 million Americans are without health insurance of any kind, and another 20 million are insured only intermittently, or have policies which do not cover catastrophic illnesses. When serious illness strikes these individuals, they become part of the medically indigent population.

Consequently, a major priority for both the public and private sector should be the implementation of methods to both reduce the number of uninsured and strengthen public programs to provide coverage for those individuals who are unable to purchase private health insurance. Appropriate actions include the strengthening of tax incentives to obtain adequate insurance, the creation of risk pools for the medically uninsurable, and the strengthening of Medicaid. Parallel actions should be taken to address the issue of catastrophic illness among the insured population. Insurers and employers should make information on the cost and potential value of catastrophic coverage more widely available, and federal policies should encourage the coverage of catastrophic illnesses by private insurance.

COMMENTS ON THE ADMINISTRATION'S PROPOSAL

We would also like to take this opportunity to provide some brief comments on the Administration's catastrophic proposal. The Medicare Catastrophic Illness Coverage Act (S.592) would: eliminate the day limitations on acute inpatient hospital care except for inpatient psychiatric hospital care; eliminate the confusing spell-of-illness concept and limit first-day hospital deductibles to two per year; eliminate all copayments for inpatient hospital and skilled nursing facility care; limit combined Part A and Part B cost-sharing for covered services to $2,000 per year; and fund these expanded benefits by adding an actuarially sound premium to the Part B premium, initially estimated to be $4.92 a month.

These proposed changes in the Medicare acute care benefit would be a first step in addressing the problem of catastrophic expenses for Medicare beneficiaries. Although there is only a small expansion of coverage, this and similar proposals would provide some relief to those beneficiaries who experience significant copayment and deductible expenses for covered services; some peace of mind for those beneficiaries frightened by the possibility of significant cost sharing for covered services; and simplification of the benefit and cost sharing provisions so that beneficiaries would be better able to assess the value of private Medicare supplemental insurance policies.

Although we urge adoption of a broader catastrophic approach, there are some modest expansions and alternative approaches that we believe would improve the extent to which S.592 deals with the acute care catastrophic needs of Medicare beneficiaries. They are: (1) better access to non-inpatient acute care services; (2) elimination of the lifetime limit on acute inpatient psychiatric hospital care; and (3) providing for income sensitivity in the financing of catastrophic coverage.

Expanding Access to Non-inpatient Care. As discussed in detail above, significant changes have occurred in methods for delivering acute care since the Medicare benefit package was originally designed. To be effective in responding to those changes, the Medicare acute care benefit should be revised to include outpatient pharmaceuticals (subject to an annual deductible and copayments) and to provide greater, more flexible use of home health and SNF services.

Eliminating the Limit on Acute Inpatient Psychiatric Care. The 190-day lifetime limit on acute inpatient psychiatric hospital care--which S.592 would leave intact--is outmoded and unnecessary. With extensive utilization controls and cost-per-case limits on payment, there is no basis for perpetuating a two-class system of coverage for psychiatric and non-psychiatric illness. It is inappropriate to substitute a limitation on benefits for effective utilization review, particularly given the active involvement of the psychiatric community in substantially improving utilization controls since Medicare was enacted.

In the past decade, there have been significant advances in psychopharmacology and biological testing that have resulted in more precise diagnoses and efficient approaches to treatment. There is also widespread and persistent evidence of the reduced rate of increase of medical expense following mental health treatment which argues for the inseparability of mind and body in health care. All public and private health insurance programs for financing health care should include benefits for the active treatment of mental illness and substance abuse and dependence that are equal to benefits provided for physical illness and disability.

Income Sensitivity in Financing Catastrophic Coverage. To generate revenues to support the expanded coverage, S.592 uses the straight-forward approach of an actuarially sound premium. This approach has the advantage of explicitly relating financing to the cost of beneficiary benefits. The primary disadvantage of a premium approach, of course, is that it is not income sensitive--an significant disadvantage for the 49 percent of the elderly whose annual incomes are less than $10,000. Furthermore, S.592 would provide the expanded coverage only to those Medicare beneficiaries who are enrolled in the Part B program. Although most beneficiaries are enrolled in both Parts A and B, almost 1 million beneficiaries are covered only by Part A and there is strong evidence to suggest that they may not be able to afford Part B coverage and are ineligible for Medicaid. A 1980 study showed that, for the most part, those with only Medicare coverage (unsupplemented by either Medicaid or private coverage) are those with the greatest medical needs and the fewest resources--people who are over 75, black, and have low income and education levels.

Although more complex, the idea of combining a universal premium with protections for low-income beneficiaries merits some examination. For example, Medicaid coverage could be restructured as an SSI supplemental package to cover copayments and pay the Medicare premium for those beneficiaries for whom even limited out-of-pocket payments would be a significant burden. For the low-income beneficiary who cannot afford supplemental insurance and who does not qualify for Medicaid coverage, counting premiums toward out-of-pocket limits and tying limits to income would be a major positive step.

CONCLUSION

Although discussions of the catastrophic care problem frequently focus on the dramatic, relatively rare, acute care expenses of the elderly, the catastrophic care problem is much broader and much deeper, extending to both young and old, uninsured and insured.

Many contend that we, as a nation, cannot afford to address all but a small portion of the problem. We submit that, as an enlightened society, we cannot afford to not address the full scope of the problem. The AHA pledges its support and cooperation in tackling this problem, building step by step toward a comprehensive approach to providing desperately needed relief for Americans from the fear of catastrophic illness and expense.

STATEMENT OF RUTH CONSTANT, PH.D., PRESIDENT, PORT ARTHUR HOME HEALTH, BEAUMONT HOME HEALTH AND WICHITA HOME HEALTH, VICTORIA, TX, ON BEHALF OF NATIONAL ASSOCIATION FOR HOME CARE

Dr. CONSTANT. Mr. Chairman, members of the committee, my name is Dr. Ruth Constant. I am President and Administrator of three small independant home health agencies in Texas. I also serve on the Government Affairs Committee of the National Association for Home Care, known as NAHC. NAHC is the largest professional organization representing the interests of home care providers with approximately 5,000 member organizations. We appreciate the opportunity to address the issue of catastrophic health insurance today.

The major proposals for catastrophic coverage currently under discussion focus on acute care, and do not address health problems outside the hospital, nor do they address the type of services most elderly Americans desire, that is, care in their own home.

The fundamental health care need of Americans is not coverage of costly catastrophic acute illnesses, but rather the coverage for chronic conditions.

Any serious catastrophic health insurance proposal must protect the elderly against the cost of long-term care and must include home health care as the first choice for provision of that care when it is medically appropriate.

NAHC recommends that Congress enact a comprehensive catastrophic health insurance plan which includes improved coverage for both acute and chronic illnesses.

A meaningful catastrophic home care benefit would require Medicare to pay for home care up to a maximum of what would otherwise be spent on the care of a patient in an institution. Such a plan would require case managers to determine alternative costs of care and to coordinate Medicare services with other services provided in the community, such as the adult day care. One example of such a program is the Nursing Home Without Walls program in New York, where the availability of a broad range of alternative services has not only maintained the frail elderly in their own homes, but has done so at an average of 50 percent of the costs that would otherwise be incurred for the patient in the nursing home.

The Nursing Home Without Walls program coordinates and manages the delivery of all services to the patient, and the local department of social services monitors the patient's monthly care costs. By statute, costs for the program may not exceed 75 percent of the average monthly cost of institutional care. This type of benefit would be a truly meaningful element of a catastrophic health insurance plan.

A less sweeping benefit, which could be provided without the development of a case management system for Medicare, could be provided by covering a limited amount of personal care to maintain functionally impaired individuals in their homes. Such assistance as part of the Medicare program could increase the situations in which these patients could remain in their homes rather than being placed in nursing homes.

Financing for either of these enhanced home health coverages should be through mandatory participation spread over the lives of workers, similar to current Medicare Part A financing. Such a method would minimize the impact by distributing the financing over the largest possible number of individuals in a progressive manner.

Due to the limited time, I will go to the recommendations, Senator.

NAHC recommends that Congress enact a catastrophic health insurance plan with a meaningful home care benefit as its focus. That home care benefit should require Medicare to pay for home care up to a maximum of what would otherwise be spent on the care of a patient in an institution. A less sweeping benefit which could be provided without the development of a case management system for Medicare, could be provided with Medicare covering a limited amount of personal care per week, to assist family and community care givers in maintaining functionally disabled individuals in their homes.

Second, NAHC recommends that Congress clarify the definition of intermittent care to include one or more visits per day on a daily basis for up to 90 days and thereafter under exceptional conditions. Daily care should be clarified to mean seven days per week.

Third, NAHC recommends that Congress clarify, and Medicare patients should be able to utilize additional payment sources without jeopardizing his Medicare benefits as long as the care paid for by Medicare is medically reasonable and necessary. The use of other payers should not be relevant to determination of Medicare coverage.

Last, to codify the current home-bound guidelines and clarify that an individual need not be totally dependent and bedridden to be considered home-bound. I thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Dr. Constant. I can't resist the chance to comment on the fact that Hospice House out in Scottsdale is a member of your organization as I understand it. And members of this committee have participated in a Senators tennis tournament out there, and raised in excess of a million dollars for Hospice House. They had set tennis back for about five years, but the Hospice has done a great job. [Laughter.]

Senator DURENBERGER. That was the year George was there, wasn't it? [Laughter.]

Oh, it was the year I played. [Laughter.]

The CHAIRMAN. Dr. Willging, would you proceed, sir?

[The prepared written statement of Dr. Constant follows:]

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Testimony Of

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Representing the National Association for Home Care
Before the Senate Committee on Finance

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REPRESENTING THE NATION'S HOME HEALTH AGENCIES, HOMEMAKER-HOME HEALTH AIDE ORGANIZATIONS AND HOSPICES

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Mr. Chairman and Members of the Committee:

My name is Dr. Ruth Constant. I am the President and Administrator of three small independent home health agencies in Texas. I also serve on the Government Affairs Committee of the National Association for Home Care (NAHC). NAHC is the largest professional organization representing the interests of home health agencies, homemaker-home health aide organizations and hospices, with approximately 5,000 member organizations. NAHC is committed to assuring the availability of humane, cost-effective, high quality home care services to all who require them.

We appreciate this opportunity to address the issue of catastrophic health insurance, because the majority of the patients we serve are the frail elderly who are most in need of financial protection to guard against the need to impoverish themselves to obtain necessary health care. Unfortunately, the major proposals for catastrophic coverage currently under discussion focus on acute care, and do not address health problems outside the hospital, such as the need for care now mostly met in nursing homes. Nor do they address the type of services most elderly Americans desire as an alternative to nursing home care, that is, care in their own homes. The fundamental health care need of elderly Americans is not coverage of costly "catastrophic" acute illnesses, but rather the coverage of the far more costly care needed for chronic conditions. According to the Senate Special Committee on Aging, under the major proposals currently being discussed, 8 out of every 10 dollars spent on catastrophic illnesses next year would not be covered. Less than three percent of all Medicare beneficiaries would be aided by these proposals. Any serious catastrophic health insurance proposal must protect the elderly against the cost of long term care, and must include home health care as the first choice for provision of that care when it is medically appropriate.

The current Medicare home health benefit is a limited one. It covers only acute services needed on an "intermittent" basis, that is, daily visits for a two to three week period, and thereafter upon a showing of exceptional circumstances. To be eligible for home health care under Medicare, a person must be confined to his or her residence (essentially homebound), be under the care of a physician, and need part-time or intermittent skilled nursing services (as opposed to daily 24 hour-a-day care) and/or physical or speech therapy. If these requirements are met, a person is eligible for the following services: skilled nursing service, physical therapy, speech therapy, occupational therapy, medical social work, and home health aide services.

I. Congress should enact a meaningful catastrophic benefit with home health care as its main focus

NAHC recommends that Congress enact a comprehensive catastrophic health insurance plan which includes improved coverage for both acute and chronic illnesses.

A meaningful catastrophic home care benefit would require Medicare to pay for home care up to a maximum of what would otherwise be spent on the care of a patient in an institution, similar to coverage under the current Medicaid home and community-based care waivers. Such a plan would require case managers to determine alternative costs of care in settings and to coordinate Medicare services with other services provided in the community, such as adult day care. One example of such a program is the Nursing Home Without Walls program in New York, where the availability of a broad range of alternative services has not only maintained the frail elderly in their own homes, but has done so at an average of 50 percent of the costs that would otherwise be incurred for the patient in a nursing home.

The Nursing Home Without Walls program coordinates and manages the delivery of all services to the patient, and the local department of social services monitors the patient's monthly care costs. In addition to regular Medicaid services, the program also offers medical social services, nutritional counseling, respiratory therapy, respite care, social day care, congregate/home delivered meals, moving assistance, housing improvement, home maintenance, social transportation, personal emergency response system, and case management By statute, costs for the program may not exceed 75 percent of the average monthly cost of institutional care. As mentioned earlier, despite these additions in services, the program is saving an average of 50 percent of the costs that would otherwise be incurred for that patient in a skilled nursing facility or intermediate care facility.

This is the type of Medicare home health benefit that would be a truly meaningful element of a catastrophic health insurance plan.

A less sweeping benefit, which could be provided without the development of a case management system for Medicare, could be provided by covering a limited amount of personal care, for example, a specified number of hours of personal care per week to maintain functionally impaired individuals in their homes. This type of care would provide a respite for families to enable them to continue to take care of older or disabled family members in their homes. It would also provide services to persons whose other needs can be met by family and neighbors where the caregivers may be reluctant or unable to provide such personal care services as bathing. These personal care services would supplement current community-based efforts, not replace them. Such assistance as part of the Medicare program could increase the situations in which these patients could remain in their homes rather than being placed in nursing homes.

Financing for either of these enhanced home health coverages should be through mandatory participation spread over the lives of workers, similar to current Medicare Part A financing. Such a method would minimize the impact by distributing the financing over the largest possible number of individuals in a progressive manner.

II. Congress should remedy problems with the current Medicare home health benefit

While working on a meaningful home care benefit to include in catastrophic health care coverage, Congress should immediately take steps to remedy problems in the current Medicare home health benefit which are limiting access to the benefit for many Medicare beneficiaries.

Recent policies of the Health Care Financing Administration (HCFA) "to restrain beneficiary protections, combined with vague and confusing guidelines for providers, result in reduced access to home health care for Older Americans", according to a report by the Senate Special Committee on Aging.

The report noted that although hospital discharges to home health have increased 37 percent since prospective payment for hospitals was implemented, the growth in home health services since then has slowed. A 1987 General Accounting Office survey of hospital discharge planners revealed that 86 percent "reported problems with home health care placements" for Medicare beneficiaries. 52 percent of those surveyed cited "Medicare program rules and regulations" as "the most important barrier" to these placements. It is no coincidence that HCFA's own statistics show that the percentage of home health claims denied under the Medicare program rose from 1.2 percent in 1983 to over 6.0 percent in 1986. And this figure does not include the many patients who are effectively denied Medicare coverage because home health agencies, incapable of assuming the costs of non-covered care, avoid Medicare claims submissions.

Intermittent Care Requirement

As noted earlier, the present HCFA guidelines allow for daily visits for a two to three week period, and thereafter, visits may be continued upon a showing of exceptional circumstances. This level of services is often inadequate to care for more acutely ill patients who are being discharged from hospitals.

In addition, definitions of what constitutes "intermittent care" vary tremendously, depending on the fiscal intermediary's (FI's) interpretation. As a result, Medicare, which is supposed to be a national program, is not enforced uniformly and what is covered for one beneficiary in one state is not covered in other state.

A related practice, known as "selective billing," has served to further restrict home care coverage for Medicare beneficiaries. If patients are receiving coverage under Medicare, in many cases they cannot receive additional coverage from Medicaid or any other payment source (private insurance, self-pay, Title XX, etc.). For example, if patient A is receiving 3 hours of nursing care and 2 hours of aide care for 3 days a week paid for by Medicare, and he or his family wants an additional 2 hours of nursing care on the other 2 days which will be paid by concerned relatives, Medicare intermediaries will deny the Medicare coverage, claiming that the patient is exceeding the "intermittent care" requirement. This either will result in no care, limited care, or the forced institutionalization of an individual whose family cannot sustain him at home if Medicare refuses to pay its fair share.

Homebound Requirement

The Medicare homebound guideline allows the patient to be considered homebound if he has infrequent or short duration absences from the home primarily for medical treatment or "occasional non-medical purposes" (e.g., trip to barber, a drive, walk around the block).

The current definition in the guidelines is interpreted in an inconsistent and varying manner by fiscal intermediaries. This is especially so in cases where beneficiaries are leaving their homes to go out for periodic adult day care, outpatient kidney dialysis, chemotherapy and other similar treatment. Even though the current guideline allows beneficiaries to go out for medical reasons, some FIs severely limit frequency and others do not honor the medical reason exception at all. In situations where individuals leave their homes for either medical or non-medical reasons, individual FIs have their own interpretations as to what they consider frequent or infrequent, or whether they consider the patient homebound if he or she leaves home with the aid of an ambulance or other extraordinary assistance.

Recommendations:

Congress should:

1. Enact a catastrophic health insurance plan with a meaningful home care benefit as its focus. That home care benefit should require Medicare to pay for home care up to a maximum of what would otherwise be spent on the care of a patient in an institution, similar to Medicaid home and community-based waivers. A less sweeping benefit which could be provided without the development of a case management system for Medicare, could be provided with Medicare covering a limited amount of personal care per week, to assist family and community care givers in maintaining functionally disabled individuals in their homes.

2. Clarify the definition of intermittent care to include one or more visits per day on a daily basis for up to 90 days and thereafter under exceptional circumstances. Daily care should be clarified to mean seven days per week.

3. Clarify that a Medicare patient should be able to utilize additional payment sources without jeopardizing his Medicare benefit, as long as the care paid for by Medicare is medically reasonable and necessary. The use of other payors should not be relevant to determinations of Medicare coverage.

4. Codify the current homebound guideline and clarify that an individual need not be totally dependent and bedridden to be considered homebound.

Mr. Chairman, I appreciate having the opportunity to testify today on these important matters. I would be pleased to answer any questions you might have.

STATEMENT OF PAUL WILLGING, PH.D., EXECUTIVE DIRECTOR, AMERICAN HEALTH CARE ASSOCIATION, WASHINGTON, DC

Dr. WILLGING. Thank you, Mr. Chairman. I commend you and I commend this committee for having helped focus attention in the policy making arena on the issue of catastrophic health care expense.

I agree with you, Mr. Chairman, that the preceding panel perhaps stated the issue as well as anyone could, and indeed were I smarter than I am, I would probably shut up at this point. But I am not, so I won't. I would rather like to underline three or four of the points that came out in the preceding discussion with that excellent panel.

And I think the first is that we had best perhaps define the problem before we search for the solutions. And indeed catastrophic health care expense is a critical problem. But the components of that problem I think are misstated in the President's proposal. And indeed, although Senator Durenberger won the debate with Bill Hutton by proclamation, I tend to agree more with Bill Hutton, that indeed it is almost appalling that the President, in submitting his proposal, can state that it would, "free the elderly from the fear of catastrophic illnesses and provide that last full measure of security."

As long as the issue of catastrophic health care expense is primarily at the tune of 82 percent, an issue related to long-term care, the President's proposal and similar proposals will not indeed provide that last full measure of security.

Why is it that the proposals made up to this point are primarily oriented toward the acute care setting? I suspect it is not because that is the most depressing gap in Medicare. I suspect it is more because it lends itself more easily than to other proposals to the issue of financing. Because as has been suggested already today, if one were to take the same approach, that is, increase the Part B premium by the amount necessary to put into Medicare a comprehensive long-term care program, $4.92 clearly would be insufficient. Yet I think we tend on occasion to lose sight of the fact that this country, through public financing sources, does pay for long-term care to the tune of $20 billion a year, primarily through the Medicaid program. Not to mention the costs, the psychological and social costs, attendant to a program which is about as inhumane as could be devised by the human mind.

We ask Americans to spend their lives developing a sense of independence, to protect themselves against the ravages of old age, and yet we say, if indeed as an act of God you do succumb to the need for long-term care, society will step in only once you have divested yourself not just of your resources, not just of your assets, but of your dignity and your sense of self-respect as well.

I would suggest that the issue is not whether this country needs a long-term care financing program. We have it. The question is whether we need one that meets the needs of individuals and how do we best go about financing that program?

We have had some discussion today already about the possibility of financing, not just through premium increases on Part B. There are other approaches. And I think if we were to seriously sit down and deal with that issue of financing we perhaps could generate approaches that meets most Americans' idea as to what makes for a fair, sane, sensible policy.

I would, in fact, perhaps disagree with Wilbur Cohen suggesting that we provide more first dollar coverage for long-term care. Perhaps what we need to do in terms of a balance of the private and the public sectors is, in fact, to build into the Medicare program a program that takes care of the truly catastrophic stay that cuts in perhaps only after two years or two and a half years, and relied to a more considerable extent than we have in the past on the private insurance market to fill in that gap.

The Brookings Institution is currently dealing with this issue of long-term care financing, and it has come up with what I think is an intriguing idea. Right now, the tax that pays for long-term care is essentially an inheritance tax. That is, if you need long-term care we ask that you wipe out your entire potential inheritance and then the government will kick in. Perhaps we ought to spread that kind of a tax across all Americans.

I suggest, in conclusion, Mr. Chairman, the solutions are there. The question is whether we as a society are ready to grapple with the problem. Thank you very much.

The CHAIRMAN. Thank you.

Dr. SCHENKEN.

[The prepared written statement of Dr. Willging follows:]

Statement of the
American Health Care Association

CATASTROPHIC HEALTH CARE COVERAGE FOR THE ELDERLY

by

Paul R. Willging, Ph.D.

American Health Care Association

before the

Committee on Finance

United States Senate

March 19, 1987

Mr. Chairman and Members of the Committee:

I am Paul Willging, Executive Vice President of the American Health Care Association the largest association representing America's long term care providers. As an association that represents 9,000 long term care facilities which care for about 900,000 nursing home patients each day, AHCA is unfortunately all too familiar with the elderly's need for financial protection from catastrophic health care expenses. Furthermore, I was privileged last year to serve on Health and Human Services Secretary Bowen's Private/Public Advisory Council on Catastrophic Illness.

In the 20 years since Medicare and Medicaid were enacted, catastrophic illness has remained the major hole in the elderly's safety net. Coverage of health care expenses under Medicare is inadequate and coverage under Medicaid is too late to protect our elderly against financial catastrophe. Clearly, you, Mr. Chairman, and other members of this committee have held catastrophic illness coverage as a national policy objective for a long time. This year, with the help of Secretary Bowen's forceful advocacy and his catastrophic illness report, I am hopeful that your leadership will ensure the passage of legislation to help close that hole in the safety net.

Although an important first step, President Reagan has greatly overstated his claims of "comprehensiveness" in his Administration's approach to providing catastrophic protection for the elderly. He has embraced his catastrophic proposal as one that would "free the elderly from the fear of catastrophic illness" and provide "that last full measure of security." Indeed, if his plan is enacted without addressing long term care, the President's claim will be a sham perpetrated on the American public. Nursing home care is by far the biggest health care risk threatening our elderly and until catastrophic protection is extended to long term care, the President's claim will be left unfulfilled.

Even the Bowen report to the President emphasizes that "long term care is the most likely catastrophic illness risk faced by individuals and families." Nursing home providers know this not only as an actuarial risk, but as a daily tragedy for thousands of Americans. Fully 82 percent of medical expenses for those individuals who incur over $2,000 in annual out-of-pocket costs is spent for nursing home care. Many are quickly forced to spend down to impoverishment to qualify for the only existing catastrophic protection -- the Medicaid program for the poor.

While I do not expect any catastrophic plan to fully resolve the financing of long term care, we must begin to make improvements in long term protection not only for the present, but for the future as well. Every demographic trend shows that the need for long term care will only increase. By the year 2000, the number of Americans over the age of 85 will have doubled. Life expectancy has improved so rapidly that today's 65-year-old can expect to reach an average age of 81. However, although medical advances have contributed to extended longevity, there have not been comparable breakthroughs in the treatment of chronic disabilities associated with old age. Nursing home utilization among those age 85 and over remains 14 times the rate of those age 65-74.

The lack of private long term care insurance and adequate personal resources will continue to force individuals to risk financial devastation in the event of long term care. Although personal savings are the first line of long term care defense, Medicaid by default has become the major public program for nursing home and post-catastrophic coverage as individuals quickly exhaust their resources. Approximately one-third of our population would be impoverished after only 13 weeks in a nursing home. Two-thirds of our elderly would exhaust their financial resources within the first year of a nursing home stay. The Bowen report notes that an estimated one half of Medicaid recipients were not initially poor, but "spent down" their income and resources before becoming eligible. Once institutionalized, such individuals seldom return to the community even if the person's condition improves because of lack of personal resources and the difficulty associated with readmitting a Medicaid patient to a nursing home. Medicaid, originally intended to protect the poor, perversely forces impoverishment, thus ensuring dependency on public assistance.

Secretary Bowen's report to the President acknowledges that heartbreak associated with catastrophic illness and displays insight, compassion and courage in proposing realistic solutions. While we differ as to the relative efficacy of the 12 options laid out to deal with catastrophic expenses, I certainly concur in the emphasis placed on the further development of long term care insurance. The following HHS recommendations are especially important:

- Encouraging the development of the private market for long term care insurance through tax code revisions;
- Allowing tax-free withdrawals from individual retirement accounts for any long term care expense; and
- Launching government and private sector education programs to inform the public about the risks, costs and financing options available for long term care.

Developing Comprehensive Long Term Care Financial Protection

However, I must stress that these recommendations are only a small part of devising comprehensive alternative financing mechanisms that would truly provide catastrophic protection for those needing long term care. Clearly, any comprehensive finaincing solution to financing must be a public/private approach that encourages independence and personal and family responsibility, but ensures that all elderly will obtain care with dignity. AHCA has been working with the Brookings Institution on financing options for long term care and we are hopeful that its report will provide some valuable input into the long term care debate. While a comprehensive system could be developed in a number of ways, I would like to offer two options for your consideration.

One option would be a system of private long term care insurance mandated as part of employer fringe benefit packages with premium financing shared by employers and employees. Under such a plan, private insurance would replace most of the long term care benefits under Medicaid. Low wage earners could have a portion of their premiums subsidized by Medicaid and non-wage earners would receive full subsidization for their premiums.

Insurance benefits would cover both institutional and non-institutional long term care up to a lifetime dollar limit and Medicaid would finance any needed long term care once their lifetime limit was exceeded on a cost-sharing basis. Coinsurance would be required up to a lifetime dollar limit with means-tested subsidization by Medicaid. A provision for respite care should be included to maintain and strengthen the informal support system, and open seasons for switching insurance carriers would ensure competition among carriers. Finally, insurance benefits could be paid either in the form of vouchers or through cost-of-service payments directly from the insurance carrier to the provider.

The second option would be a modest Medicare long term care benefit to be supplemented by private insurance and other resources and by a much reduced Medicaid program for the very poor. Under this approach, Medicare could provide catastrophic coverage only with benefits that would not begin until after a long deductible period, such as two years, thus providing incentives for individuals to purchase supplemental private insurance. Other modest Medicare programs for long term care could be designed with substantial coinsurance and deductibles as with the current Medicare program, or with income-related benefits.

On a more limited scale, the Congress must continue to examine immediate short-term steps to address the financial risk of long term care facing our elderly.

Promoting Private Long Term Care Insurance

With better market research and risk analysis, private long term care insurance can become a viable financing option in the not too distant future. While private long term care insurance is a relatively new option, it is encouraging to note that a number of insurers have entered the market with some coverage during the past two years. Private insurance, however, should be viewed pragmatically as offering little immediate hope to those with pre-existing chronic or catastrophic care needs unless federal incentives are developed to stimulate the market.

Federal tax incentives aimed toward the creation of private insurance should include:

- major tax credits to individuals and employers for the purchase of long term care insurance;
- accelerated write-off of research and development expenses by insurance companies for research and development on long term care insurance products; and
- special tax incentives for premium advances, premium income and loss reserves.

Medicaid savings on long term care would substantially offset revenue losses from federal tax incentives.

Private long term care insurance could be promoted by allowing Medicaid plans to pay for premiums for private long term care insurance for Medicaid recipients, at least on a demonstration basis. With the growing availability of private long term care insurance, new state authority to serve the non-Medicaid elderly poor, and increasing talk of establishing state risk pools, this proposal could be an important tool in long term care protection. Under this option the state would have maximum flexibility to select prospective insurees, customize protection packages and make all financial arrangements with the insurors. Currently, state Medicaid programs may include a variety of optional coverages, but not for health insurance or other payments to non-providers of medical services. The most applicable payment arrangement would be to prepaid health plans.

Improving Medicare Nursing Home Coverage

If Congress fails to substantially expand Medicare to cover long term care services this year, it should at least make changes to ensure that the current skilled nursing benefit can be utilized as Congress intended.

The current patient cost-sharing for Medicare beneficiaries for the SNF benefit is so high that it exceeds the private pay rate in most facilities. At $65 per day from the 21st day to the maximum 100th day Medicare SNF benefits cease, in effect, after 20 days. On this point, AHCA strongly supports the provision in the Administration's bill, S. 592, which has the cosponsorship of many of the members of the Committee, to eliminate the patient cost-sharing requirement for SNF services.

Second, we recommend the elimination of the confusing "spell of illness" requirement for determining eligibility and setting a 150 day annual maximum of SNF days. Most catastrophic proposals which have been introduced, including the Administration's, eliminates the "spell of illness" coverage determination for hospital care and the same should be applied to SNF coverage.

Third, we propose elimination of the minimum 3-day prior hospitalization requirement for SNF benefit coverage because it is neither cost effective nor necessary to control inappropriate utilization.

Lastly, the Congress must address the barriers that discourage nursing homes from participating in the Medicare program, thus creating severe patient access problems in much of the nation. The General Accounting Office recently reported on the difficulty of patients gaining needed SNF placement, with many remaining "backed-up" in expensive hospital settings. The burdensome and inefficient retrospective cost-reimbursement system for SNFs has ensured that only a fraction of nursing homes provide SNF coverage. As you know, AHCA encourages the development of a Medicare prospective payment for SNFs based on patient case-mix. One important incremental change would be building on the "low volume SNF" prospective payment option that Congress provided for SNFs with less than 1500 patient days per year by making it available to SNFs with up to 2500 annual Medicare days (an average daily census of less than 7 Medicare beneficiaries).

Attention also should be given to a growing number of retrospective SNF claim denials which is creating hardships for Medicare beneficiaries and confusion among providers. Fiscal intermediaries across the country are tightening eligibility standards in a seemingly capricious and arbitrary fashion which has severely constrained Medicare SNF caseload and caused regional inconsistencies. Evidence from our membership indicates that 80 percent of these denied claims are being overturned in the appeals process. AHCA believes that a prior authorization system is needed and that fiscal intermediaries should be strictly bound to established HCFA eligibility criteria and regulations.

Educating Consumers about Long Term Care Risk

A study conducted by the American Association of Retired Persons indicates that 79 percent of Americans erroneously believe that Medicare covers most nursing home and long term care services. Clearly there is a lack of comprehension about the prevalence of need for long term care or what the cost of long term care would be for the average person. Consequently, there has been a lack of demand for private long term care risk protection and only modest progress in the development of private insurance options. An aggressive education campaign must be waged to encourage individuals to make adequate plans for their own care in old age.

The Social Security Administration and the Health Care Financing Administration should be required to inform the public in easily understood language that Medicare does not cover long term care and that most Medigap insurance policies address gaps in acute care coverage, not long term care needs. AHCA supports H.R. 977 which would initiate a two-year educational program by the Secretary of HHS in consultation with the National Association of Insurance Commissioners, the Task Force on Long Term Care Policies and other government and industry representatives.

Additionally, we feel that the Older Americans Act should be amended to require that state plans disseminate information on the risks, costs and financing options of long term care through their area agencies on aging.

In summary, I want to extend to the Committee the assistance of the American Health Care Association in taking advantage of this rare political interest in catastrophic coverage to achieve major advances in long term care financing.

STATEMENT OF JERALD R. SCHENKEN, M.D., MEMBER, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION, OMAHA, NE

Dr. SCHENKEN. Thank you, Mr. Chairman.

For many years, the AMA has advocated catastrophic coverage as a part of a package of minimum benefits in all health insurance plans. Such catastrophic coverage can often be provided at relatively small additional cost. We believe that ideally the addition of catastrophic coverage to current Medicare benefits should be accomplished as part of a broad reform of the Medicare program.

We started our project to look at this, recognizing that the current Medicare plan is structurally unsound. There is no catastrophic coverage. It has high out of pocket payment cost to the beneficiaries. It is pay as you go; it is not pre-funded. And it is heading for bankruptcy by everybody's agreement. The only debate is when.

With this in mind, we developed a proposal for financing health care services for the elderly that is financially sound and would provide comprehensive protection, including catastrophic coverage. A summary of our plan is included in our written statement.

I would like to emphasize at this point, Mr. Chairman, that our plan is conceptual, and we would hope to work with you and the entire membership of the committee on the details as it goes along.

The AMA recognizes that the catastrophic coverage issue is being addressed by Congress prior to long-term reform in the Medicare program because of appropriate concern for the risk of catastrophic expense faced by the elderly. While we support the intent of proposals of Secretary Bowen and others to expand Medicare to provide catastrophic coverage, we believe that catastrophic coverage could be provided more efficiently and effectively by the private sector.

Currently, about 70 percent of Medicare beneficiaries have so-called Medigap policies. These policies already provide a considerable degree of catastrophic protection because they must meet the minimum standards established by existing federal law.

We do recognize that gaps in the Medigap coverage do remain. We believe that before federal action to expand Medicare is undertaken, however, the private sector should be afforded the opportunity to close these coverage gaps and provide the benefits proposed by Secretary Bowen at a comparable cost.

Already one major insurance company has reportedly stated that it can offer the benefits provided in Secretary Bowen's proposal at no additional cost.

Private insurance companies should also voluntarily expand upon and broaden Medicare benefits. For example, increased coverage could be provided for expanded nursing home services beyond the restrictive Medicare qualifications and could even include some intermediate care nursing services. And we have heard several of the previous witnesses comment on this area earlier.

Innovative approaches should be explored for providing catastrophic coverage for the 20 percent of the elderly who have neither Medigap nor Medicaid coverage. For example, vouchers could be provided to such persons to help them pay the premiums for private Medigap policies that include catastrophic protection. Alternatively, Medicaid spend down provisions could be liberalized to allow these persons to become eligible for Medicaid after they occur a specific amount of out of pocket cost.

If the Congress decides to provide catastrophic coverage through expansion of the Medicare program, such coverage should provide some form of means testing. Any government-funded catastrophic coverage program should also be limited to acute health care cost. Otherwise, the program would become much too costly. That isn't to say other problems aren't great, but we are concerned about the integrity of the program.

Broad personal and family responsibility for long-term care should be encouraged through appropriate tax and savings incentives.

Mr. Chairman, while the focus of this hearing is on providing catastrophic coverage for the elderly, the needs of non-elderly should not be overlooked. The AMA believes that adequate health insurance, including catastrophic coverage, should be furnished in the employment setting. Workers who are laid off, for instance, should have the opportunity to maintain employment-based health insurance for at least several months after their termination if they continue to pay the same portion of the insurance premium they paid while they were employed.

Mr. Chairman, it is our pleasure to be here and to participate in these deliberations. And I will be happy to answer any questions the committee may have.

[The prepared written statement of Dr. Schenken follows:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Committee on Finance
United States Senate

RE: Catastrophic Coverage for Health and Long-Term Care Needs

March 19, 1987

Mr. Chairman and Members of the Committee:

The AMA is pleased to have this opportunity to testify concerning the important issue of catastrophic coverage for health and long-term care needs. For many years, we have advocated that catastrophic health care coverage should be included as part of a package of minimum benefits in all health insurance plans. Such catastrophic coverage can often be provided at relatively small additional cost. In addition, even though the vast majority of persons would never actually use the catastrophic benefit, its mere existence would provide vital piece of mind.

Mr. Chairman, in discussing catastrophic coverage, it is important to keep in mind that what constitutes a catastrophic expense varies from person to person -- based on individual financial resources. An expense that clearly would be catastrophic to a person relying solely on Social Security cash benefits might be manageable for an individual with a substantial annual income.

Catastrophic care expenses can be divided into two categories: acute health care costs and long-term custodial care costs. Effective steps should be taken now to assure all our citizens, including Medicare beneficiaries, that they will not become impoverished if faced with large acute health care expenses. Efforts should also be increased towards developing mechanisms to cover the potentially catastrophic expense of long-term care.

Acute Care Catastrophic Costs for the Elderly

AMA Proposal

Ideally, the addition of catastrophic coverage to current Medicare benefits should be accomplished as part of a broad reform of the Medicare program to assure its continuation. With this in mind, we have developed a new program, one that is fiscally sound and will assure health care services for the elderly well into the 21st century. Our proposal would provide comprehensive protection, including catastrophic coverage. A summary of our proposal is attached to this statement as an appendix.

Advantages of Private Insurance

The AMA recognizes that the catastrophic coverage issue is being addressed by Congress prior to long-term reform of the Medicare program because of appropriate concern for the risk of catastrophic expense faced by the elderly. While we support the intent of proposals by Secretary Bowen and others to expand Medicare to provide catastrophic coverage, we believe that such coverage is better provided through private insurance rather than under a government program.

The AMA believes that catastrophic coverage could be provided more efficiently and effectively by the private sector. Currently, about 70% of Medicare beneficiaries have Medigap policies. These policies already provide a considerable degree of catastrophic protection because they must meet the following minimum standards as a result of Congressional mandate:

- coverage of Part A inpatient coinsurance for Medicare eligible expenses from the 61st through 90th day of hospitalization in any "spell of illness";
- coverage of Part A inpatient coinsurance for Medicare eligible expenses incurred during use of Medicare's lifetime reserve days (91st through 150th day of hospitalization);
- upon exhaustion of all Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 90% of all Medicare Part A eligible expenses for a lifetime maximum of up to 365 days; and
- coverage of Medicare Part B coinsurance up to at least $5,000 per year, subject to a maximum annual out-of-pocket deductible of $200.

We recognize, however, that gaps in Medigap coverage do remain. For example, the minimum standards for Medigap policies do not require that Part A coinsurance for the 21st through the 100th day of skilled nursing facility care be covered or that such policies provide coverage beyond the 100th day of a stay. We believe that before federal action is undertaken, however, the private sector should be afforded the opportunity to close these coverage gaps and provide the benefits proposed by Secretary Bowen at a comparable cost. While some companies offer broad coverage, Congress could modify the minimum standards for Medigap policies to require that meaningful catastrophic coverage be included in all policies.

Private insurance companies should also voluntarily expand upon and broaden Medicare benefits. For example, increased coverage could be provided for expanded skilled nursing services, beyond the restrictive Medicare qualifications. Such coverage could even include intermediate care nursing services. Other types of coverage beyond Medicare's strict coverage and reimbursement limits should also be offered.

Coverage for Indigent Elderly

Currently, about 20% of the elderly have neither Medigap nor Medicaid coverage. Most of these persons are poor or near-poor, but are not eligible for Medicaid. Innovative approaches should be explored for providing catastrophic protection for these persons. For example, vouchers could be provided to such persons to help them pay the premiums for private Medigap policies that include catastrophic protection. Alternatively, Medicaid's "spend down" provisions could be liberalized to allow these persons to become eligible for Medicaid after they incur a specified amount of out-of-pocket costs.

In any event, in order to provide coverage for this group, some financial assistance is necessary.

Imposing an additional Part B premium may force some beneficiaries out of the Part B program, exposing this vulnerable population to increased risk. It would be more equitable to provide assistance through a means-tested combined catastrophic and basic Part B premium.

Government-Funded Program

If Congress decides to provide catastrophic coverage through an expansion of the Medicare program, such coverage should be limited to acute health care costs. Otherwise the program would become much too costly. In addition, any government-funded catastrophic coverage program should provide some form of means-testing.

Long-Term Care Catastrophic Expenses for the Elderly

The great area of uncertainty concerning catastrophic insurance is the extent, if any, to which such coverage should include long-term custodial care. The average cost of nursing home care is about $22,000 per year. As a result, such care often generates catastrophic expenses. As noted above, we do not favor inclusion of coverage for custodial services in a government-funded health program. We are particularly concerned that the 60% to 80% of the long-term care now provided to the disabled elderly by spouses, other relatives and/or friends would be shifted to taxpayers.

Broad personal and family responsibility for long-term care should be encouraged through appropriate tax and savings incentives. Like Secretary Bowen, we believe that personal savings for long-term care should be encouraged by permitting tax deductible contributions to an Individual Medical Account and by allowing tax-free withdrawal of Individual Retirement Account funds for any long-term care expense. We also support the principle of a refundable tax credit for long-term care insurance premiums in order to stimulate the private market for long-term care. Other tax incentives should be explored to encourage family responsibility for meeting long-term care needs. In addition, barriers to prefunding long-term care benefits provided by employers to retirees should be removed. Finally, we believe that the federal government and the private sector should work together to educate the public concerning the absence of coverage for long-term care under Medicare and Medigap policies.

Catastrophic Coverage for the Non-Elderly

While the focus of this hearing is on providing catastrophic coverage for the elderly, the needs of the non-elderly should not be overlooked.

The AMA believes that adequate health insurance, including catastrophic coverage, should be furnished in the employment setting. Such coverage can and should be encouraged by limiting the deductibility of employer health insurance premiums only to employers who furnish health plans that provide such coverage and who participate in a statewide risk pooling program. Risk pools can make basic health insurance (including catastrophic coverage) available, at reasonable cost, for persons who are uninsured, underinsured or uninsurable. Risk pools have been enacted in twelve states.

The current exclusion under the Employee Retirement Income Security Act (ERISA) of self-insured companies from state regulation has created an insurmountable impediment to the establishment of effective state risk pools. We strongly urge appropriate amendments to ERISA that would allow states to regulate self-insured health plans for the purpose of requiring them to comply with state laws, including those requiring risk pools.

Workers who are laid off should have the opportunity to maintain employment-based health insurance for at least several months after their termination if they continue to pay the same portion of the insurance premium they paid while employed. In addition, we support the recently enacted legislation that requires employers to make group rate coverage available for terminated workers at the worker's sole expense for an additional 18 months.

Conclusion

The AMA believes that providing coverage for catastrophic acute care costs can be achieved at small additional cost and should be aggressively pursued. We believe that such coverage can be provided more comprehensively by the private sector than under the expanded Medicare proposals. If Congress decides, however, to provide catastrophic coverage through Medicare, such a program should be limited to acute health care costs and should provide some form of means-testing. We believe that broad personal and family responsibility for long-term care should be encouraged through appropriate tax and savings incentives.

Mr. Chairman, I will be happy to answer any questions Members of the Committee may have.

2954p

REPORT OF THE BOARD OF TRUSTEES

Report: MM
(A-86)

Subject: Proposal for Financing Health Care of the Elderly (Resolutions 24 and 83, I-85)

Presented by: William S. Hotchkiss, M.D., Chairman

Referred to: Reference Committee A
(Brad P. Cohn, M.D., Chairman)

Summary

Background and Goals

In this report, the Board of Trustees describes the continuing problems with the Medicare program and presents a new approach, developed by the Council on Medical Service and Council on Legislation, for financing health care of the elderly. Previously, interim measures for reform of the current program were approved by the House in Board Reports LL (A-84) and O (I-84). This report also addresses Resolutions 24 and 83 (I-85), which were referred to the Board of Trustees.

The goals of the proposed program are to:

-- maintain access to affordable high quality health care for the elderly;

-- provide for a prefunded program;

-- provide for comprehensive protection, including catastrophic coverage;

-- provide for equitable means testing;

-- provide benefits through the private sector through pluralistic means, with recognition that a voucher would provide a beneficiary with a choice of source of coverage;

-- allow for additional contributions to IRAs for funding supplemental elderly health care expenses;

-- provide for gradual increase in age of eligibility.

Past House Actions: I-85: A-85:96-97; I-84:60-65;
A-84:158-177

The Board and the two Councils emphasize that the specifics of the proposal outlined in this report represent one feasible combination of elements in the new approach for financing health care of the elderly. The specific elements outlined herein may need to be altered, and can be, once the proposal is under discussion and debate before a wider audience. It may become desirable, for example, to reduce the cost-sharing limit for low-income individuals by increasing the tax rate, or to extend the period of time needed to achieve prefunding.

Current Medicare Program

The current program is headed for bankruptcy. While there are currently about four workers paying taxes to support each beneficiary, by the middle of the next century there will be only two workers for each beneficiary.

According to 1986 Medicare reports, by the late 1990s the Part A trust fund will be totally exhausted. It will be $1 trillion in debt by the year 2010, according to recent estimates by Health and Human Services Secretary Bowen.

The Medicare financing mechanism is flawed. Its pay-as-you-go system creates an intergenerational transfer of resources and is adversely affected by the deteriorating worker-to-beneficiary ratio. Other major flaws of the current system include its lack of catastrophic protection, lack of equitable means testing to keep cost down, and its burdensome government administration.

New Proposed Program

The proposal developed by the Councils and the Board provides universal eligibility based on age, and protects access through creation of a fiscally and actuarially sound financing approach to achieve prefunding.

The proposal provides catastrophic protection and equitable means testing, with out-of-pocket spending limits for most beneficiaries set at $2,500/year for individuals and $3,750/year for families (i.e., husband and wife). The limits on out-of-pocket spending are reached by combining a uniform coinsurance limit with a deductible that varies in amount in relation to individual or family income.

Following enactment, each eligible individual and family (husband-wife) would receive an annual voucher for the purchase of an adequate benefits policy from an approved insurance carrier or other health plan. The voucher amount would differ according to geographic area and would reflect the applicable deductible and coinsurance.

The proposal allows for additional significant contributions to IRAs ($500/individual and $1,000/husband-wife), and for tax-free withdrawals from such IRAs for health expenses after reaching eligibility age.

There would be a gradual increase in age of eligibility for benefits under the new program from 65 to 67, at the rate of three months per year.

The new program would be financed by eliminating the current 1.45% payroll tax on employees and replacing it with an initial tax of 1.75% on adjusted gross income up to $100,000. For about 95% of individuals, this would mean a net increase of .3 percentage point in their tax obligation. The payroll tax on employers would be continued, with a modest (less than 1 percentage point) increase in the current 1.45% rate. Although the initial tax rates for both employers and individuals under the Councils' proposal are slightly higher than existing rates under the Medicare program, the future rates for the new program are considerably less than those combined payroll and general revenue taxes (and Part B premium costs) which would be needed in the future to fund the current Medicare program on a fiscally sound basis.

The CHAIRMAN. Thank you, Dr. Schenken.

Mr. McDaniel, you noted in your statement that changes in health delivery programs have created new patterns of catastrophic expense. What can you tell us about the prospective payment program? Has it changed the beneficiary's needs for transitional health care? Can you give me some examples of where that has been affected by shorter lengths of time in the hospital?

Mr. McDANIEL. Well, I think the changes in the payment system, pre-DRG changes, allowed the patients to be based in the hospital setting until an appropriate post-hospital or sub-acute care facility could be located. What has happened subsequent to that change is that patients are being dictated out of the acute setting, and there is no adequate, in many cases, facility for them to be received into. And patients either go home prematurely or, in many cases—most cases, I might add—stay in the hospital beyond the coverage date under the Medicare program, therefore incurring rather substantial uncompensated care bills in the hospital setting. It is very, very difficult for the hospitals and acute facilities because they find themselves between a rock and a hard place trying to find an adequate environment for the patient to recover in outside of the acute setting. At the same time, those facilities are not available because the patient doesn't have the resources. Being burdened with the financial results mean that the hospital basically assumes that responsibility, and it goes directly to the bottom line in the way of losses.

The CHAIRMAN. Well, let me follow up on that some more by asking some of the others here. Your institutions treat some of the most critically ill and some of the most economically vulnerable patients, and yet many of those patients cannot make up the costs that is their share of the burden.

If we fill in those gaps in Medicare, how is it going to affect your institutions?

Dr. WILLGING. Well, I think the primary effect on the institution will be in dealing with the psychological turmoil that comes about when an individual does recognize, one, upon admission to the institution that the Medicare program, as far as long-term care is concerned, is really a hollow promise. And it is unfortunate that is the first point at which most Americans recognize that Medicare does not cover long-term care.

The second point, of course, is the issue of spend down and the degree to which the individual does discover that the asset base, the resources, the income must all go into long-term care. I think that will perhaps even in a very true sense provide a therapeutic benefit, that the facility can concentrate on dealing with the physical infirmity, the mental infirmity of the patient, and not deal with this extraneous and very, very disconcerting aspect of long-term care.

The CHAIRMAN. Dr. Schenken made some comments about means testing. But how about some of the others? If you would comment on how you think we ought to pay for this. You have listened to the previous panel and some of their suggestions. Do you have any comments on how do you think these costs should be shared, any of you?

Dr. SCHENKEN. Mr. Chairman, again, we want to emphasize that we think there is a significant problem of placing catastrophic coverage on the top of a program that is already heading for disaster. And so we think a variety of proposals are appropriate in light of budget concerns. If we can permit the private sector to expand as much as they can, if we can put in a means test, we think it ought to be done on the premium side. But we are open to discussions on reflecting mean on the tax side or on the benefit side. We are open on that.

We must restructure it so that we do not commit ourselves to ultimate failure. For example, the proposal to increase the taxable wages, subject to the HI tax fails to reflect that, those taxable wage increases have already been allocated in the assumptions that the Social Security Advisory Commission has made. So if we increase taxes now to fund catastrophic, we are just going to undermine the funding of the existing Part A trust fund by robbing from the future to pay for the present. We just do not think it will work. So we think our proposal is more in line with the needs of the people and the fiscal constraints of the government.

Dr. WILLGING. One point unanimously and strikingly made by all of the three previous panel participants, Mr. Chairman, was the fact that four of the types of well defined benefits among the top priorities expressed this morning, there is the willingness of the beneficiary, that is, the elderly themselves, to pay for those benefits. And I think that was an important point.

The CHAIRMAN. Oh, I got the feeling that it wasn't that they pay for all of those benefits but a sharing of those benefits, a sharing of the cost.

Senator Daschle.

Senator DASHCHLE. Thank you, Mr. Chairman.

Just in line with the previous panel, I would like to ask the same question with regard to prioritization because that seems to me to be the central focus here. We know we are going to make some change. We know at the very least we will probably have something into the Bowen bill.

If you had to list, as they had to, the top first, second and third priorities, very quickly, given the time constraints that we have, could I start with each panel member and have you give me your list? I would like to see how similar they are.

Mr. MCDANIEL. Well, I think, number one, you need to expand the coverage for acute care followed by expanding coverage on subacute, then into the transitional care, and then the non-institutional care priority because that is really, in terms of the impact on the patients and their families, where the most intense or, if you will, acute impact comes.

Senator DASCHLE. And this is both over the age of 65 and disabled?

Mr. MCDANIEL. That is absolutely correct, yes.

Senator DASCHLE. All right.

Dr. CONSTANT. Senator, for home health, I would think expanding the long-term care coverage. One of the problems is when you deal with a senior citizen, whether it is acute or chronic, to a 45 year old, you may have an acute arthritis attack, but to a chronic 80 year old, any attack that that person has is acute because it is just as painful. And so these people are literally falling between the gaps because no one is taking care of them. And in home health, the intermittant is very clearly defined in the congressional guidelines, but it is not being interpreted and implemented by HCFA accordingly, in our opinion.

Senator DASCHLE. But you have just given me, if I understand your answer, that is just the first priority. Is that in addition to what——

Dr. CONSTANT. I would say in order to expand home health care it is certainly going to have to be clarified and clearly defined, because what we are supposed to be able to provide now, we are being deprived of providing the patient, and the patient is the one that is suffering.

Senator DASCHLE. Dr. Willging.

Dr. WILLGING. You recognize, of course, Senator, that since we all represent provider types, our objectivity leaves something to be desired.

Senator DASCHLE. Well, I understand, which is why I asked the question, because obviously it is a different constituency.

Dr. WILLGING. Therefore, I would like to move my response to your question into the realm of purely objective data. And I will take simply the percentages.

Senator DASCHLE. I will take it as such.

Dr. WILLGING. And I will, therefore, follow the percentages. 82 percent of catastrophic costs experienced by the elderly as long-term care, 10 percent is hospital and 6 percent is physician. Therefore, my priorities would follow the data: long-term care, hospital care, physician care, in that order.

Senator DASCHLE. Sixty-five and older and disabled?

Dr. WILLGING. This is for the 65 and older population.

Senator DASCHLE. Only?

Dr. WILLGING. Yes.

Senator DASCHLE. Dr. Schenken.

Dr. SCHENKEN. Senator, I think you have to recognize the realities of the time. And so we feel that you have to do what you can do. I think our number one priority is to start the restructuring of Medicare because we have a short term disaster which must be avoided. Number two would be catastrophic coverage. We think we can do it. Number three, we have to look at long-term care and prescription drug costs, but the expense of these and the lack of knowledge about how to finance them put them down the priority line. That is not to say they are unimportant. They are extremely important. But we must do what can be done first. That would be our list.

Senator DASCHLE. Thank you, Dr. Schenken.

I am quite a novice to much of this discussion, and I appreciated Dr. Willging's statement earlier that we are already paying for it. It is the question of how it is distributed. And I would address that statement to you, Dr. Schenken. You would agree, I am sure, that we are paying for it now, and that there has to be a more equitable distribution of responsibility. And your argument, and a persuasive one at that, is that it ought to be more in the private sector, the emphasis need to be put on the private sector.

Can you assure equitable distribution of responsibility and still maintain a private sector initiative in this regard?

Dr. **Schenken**. I think we can. We are not suggesting overnight that we return to the private sector. What we are suggesting is that to add these benefits, we expand on the expertise in the private sector, and then at the same time restructure the Medicare program so that it can perform its functions.

So, yes, I think we can by putting them together in some fashion similar to what we have suggested.

Senator **Daschle**. I see my time is up. Thank you, Mr. Chairman.

The **Chairman**. Thank you very much. Thank you very much. We appreciate it.

Our next panel consists of Dr. Richard Materson, president of the American Academy of Physical Medicine and Rehabilitation, Houston, Texas, on behalf of the American Academy of Physical Medicine and Rehabilitation and the American Congress of Rehabilitation Medicine; and Dr. J.E. Stibbards, president of the Children's Hospital of Buffalo, Buffalo, New York, and chairman, board of the Trustees of the National Association of Children's Hospitals and Related Institutions; and Mr. Gary Shorb, president, Regional Medical Center at Memphis, on behalf of the National Association of Public Hospitals. Well, I am particularly pleased to see an old friend, Dr. Materson, here, and it is nice to have you testifying before us.

I see that we also have Doris Nash, as public affairs director, Cancer Care, Inc., New York, New York. If you would come forward, please. And Camilla M. Miller, member of the board of trustees, National Alliance for the Mentally Ill, Richmond, Virginia, on behalf of the National Alliance for the Mentally Ill, an American Psychiatric Association. If you will come forward, please.

Dr. Materson, if you would proceed, sir.

STATEMENT OF RICHARD MATERSON, M.D., PRESIDENT, AMERICAN ACADEMY OF PHYSICAL MEDICINE AND REHABILITATION, HOUSTON, TX, ON BEHALF OF THE AMERICAN ACADEMY OF PHYSICAL MEDICINE AND REHABILITATION AND AMERICAN CONGRESS OF REHABILITATION MEDICINE

Dr. **Materson**. Thank you, Senator Bentsen. Your blinking red light makes me be more efficient this morning.

I am a physiatrist, and that is a medical specialist in rehabilitation. And my Academy is the group of Boarded specialists who do medical rehabilitation. The Congress of Rehabilitation Medicine also adds the allied health specialists and other rehabilitationists. And I am also testifying for the National Association of Rehabilitation Facilities today which represents that group.

In short, what we do is we are provided the privilege of medical rehabilitation services to humans who are struck with catastrophic illness. We deal with them from infants with birth defects, children with CP, muscular distrophy, and all age people with stroke, head injury, spinal cord injury, multiple sclerosis, Parkinson's disease and others.

What we do is we plan an individualized treatment program, the sole purpose of which is triumph over adversity, attainment of maximal self-sufficiency and independent living, and return of that patient to a creative and productive role in his family and in his community. And that is what these patients crave.

In two words, I am a function doctor. And doing my job requires me to be a patient advocate, steering the patient through the quagmire of rules and regulations necessary to get the job done.

Now I have provided written testimony for the record, sir, and I would like to highlight several main points. First, I would like to say that catastrophic illness is no respector of age, sex or race. We are all vulnerable. We each deserve to be protected against the extraordinary cost associated with these illnesses and the cost of their rehabilitation, regardless of our age of onset of diagnosis. So whether it is private insurance or government, the benefits or entitlement must be adequate for the task, because if they are not, the loss is not simply to the patient and the family, but to society as well.

Senator Durenberger said it. If you add up the costs of doing it, you also have to look at the cost of not doing it.

Now imagine for a moment, sir, that, like Presidential Press Secretary, James Brady, through no fault of your own, you are cut down in the prime of your life by an assassin's bullet, causing you severe brain injury. Look at the disruption of your life and that of your loved ones, and those who depend upon you for service. Consider not only the emotional tragedy but the expenses of your illness: the ambulances, the ER charges, the operating room costs, nurse surgical intensive care, physicians' bills, laboratories, x-rays, that go on long and long, never ending illness. The disease sticks with you for the remainder of your life.

It is easy to cap the start of that cost at the time the bullet strikes the head and to reach some catastrophic amount. But contrast with that for an example that you are the father of a bright 17 year old girl who suddenly has multi-articular arthritis, a disease that waxes and wanes, the cost of which are very high some months and low other months. But, nevertheless, all through life a higher percentage of disposable income then is ordinarily spent for health. And in that case, may not be able to obtain employment, may not be able to get insurance because you already have a disease that prevents your getting insurance. And how do we then start the timer and reach a catastrophic cost? Where does the clock start? Where does it end?

If, in fact, you do not have the money to continue with your care—Mr. Brady, we think, did—what would happen to an individual who is struck like that? He loses his job usually at the time that he is catastrophically ill. But that is just when his expenses go up. His insurance almost never is adequate to catastrophic rehabilitation care. And when does he find out about it? Somebody else said it here, when it happens. That is when most people first look at whether their insurance covers them.

Now, we say, okay, I am a worker. Medicare will take care of me. But it doesn't. For two years, if you are under 65, after you have been injured, in the very prime of time when rehabilitation services should be helped, what do we do? We provide not one cent of Medicare coverage because of the 2-year wait. And if you are not insured somewhere else, you say, uh huh, there's Medicaid. It will drop in.

In the State of Texas, sir, not one cent of Medicare dollars may be spent for rehabilitation services at this time. So those people are stuck without anything until it is too late.

I think that the major things I would like to say, and some are covered, is, one, we need education in the purchase of health care insurance. Colleges, universities, high schools ought to teach consumers how to buy it.

Two, we need full disclosure and truth in advertising in insurance at every level, both Medigap and elsewhere. It should say, if you were struck with a catastrophic illness, we would cover you for 60 days and that is it. If you want other coverage you have got to buy it.

Three, I think that we have to be protected now from arbitrary and capricious intermediary rulings that are done every day under the current law, that in one State would permit a hip fracture patient to be admitted to a rehabilitation hospital and another state not to be, regardless of co-morbidity. Not medical necessity, but where he lives determining his benefits.

The craziness of limitation of inpatient hospital visits to three per week when that can't do the job, an arbitrary intermediary ruling. The silliness of not allowing home care benefit on a needed basis but on some intermittency rule. I would say to you we can make rule changes by a national rule making program that allow appropriate testimony and congressional oversight to assure the benefits we currently have.

So I say for the catastrophically ill, fill the gaps, take care of the things that they need. We do agree with some of the previous testimony that we must get onto the business of long-term care support as well, but we think we have to do that starting now, paying for it now, and obtaining the benefit later.

And I have read the AMA proposals and I agree with many of them. And I think they should be considered.

I would be happy to answer other questions.

The CHAIRMAN. Doctor, I appreciate your testimony. You deal with the realities of the problem and we appreciate the benefit of your experience.

Dr. MATERSON. Thank you, sir.

The CHAIRMAN. Mr. Shorb, please.

[The prepared written statement of Dr. Materson follows:]

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Testimony of Richard Materson, M.D.

on behalf of the

American Academy of Physical

Medicine and Rehabilitation
and the

American Congress of Rehabilitation

Medicine
before

The Senate Finance Committee

on

Catastrophic Illness Protection

March 19, 1987

Introduction

Mr. Chairman, it is a pleasure to appear before this Committee to discuss the very important question of catastrophic health insurance coverage for Americans of all ages and incomes. I am Richard Materson, a physician and President of the American Academy of Physical Medicine and Rehabilitation, and I am testifying on behalf of that organization and the American Congress of Rehabilitation Medicine of which I am a member. I am a private practitioner in Houston, Texas, and I have an academic affiliation with Baylor College of Medicine. I was also Chief of Medical Staff at Memorial Hospital in Houston. The American Academy of Physical Medicine and Rehabilitation is a medical specialty society of those physicians who are board certified and practice in the field of physical medicine and rehabilitation. There are approximately 3,000 physicians and residents in this field but we are still far short of the predicted need of at least 4,000 by the Graduate Medical Education National Advisory Council. The American Congress of Rehabilitation Medicine is a multidisciplinary professional society of physicians from all specialties, nurses, therapists, social workers and other rehabilitation professionals.

Medical Rehabilitation Care: It's Nature and Cost

Catastrophic health insurance is of importance to professionals in the field of rehabilitation medicine because we deal with patients who are severely disabled and chronically ill on a day to day basis. Rehabilitation medical professionals provide services in hospital inpatient settings, including rehabilitation hospitals and rehabilitation units in acute hospitals, and skilled nursing facilities (SNF), as part of home health programs and in organized outpatient rehabilitation settings. Patients whom we see in these rehabilitation settings include victims of stroke, spinal cord injury, head injury, arthritis, amputations and individuals with severe neurological diseases such as multiple sclerosis and Parkinson's disease. Our patients are from all age groups. For example, we see infants who suffer from cerebral palsy and cystic fibrosis; adolescents who have severe orthopedic impairments; young adults and middle age adults who suffer from spinal cord injury and head injury; and older adults, including many Medicare patients, who suffer from arthritis and stroke. The rehabilitation patient, particularly the Medicare patient, often has multiple complications further increasing the need for and cost of care. These complications include for example, skin pressure sores, contractures, loss of bladder and bowel control and cognitive and behavioral disorders.

The primary emphasis of physical medicine and rehabilitation, regardless of diagnosis or care setting, is patient function with the goal of maximum self-sufficiency. Physicians involved in physical medicine and rehabilitation are involved in both substantial diagnostic and evaluative work and in the medical rehabilitation management of patients who have severe disabilities and need comprehensive rehabilitation services. Rehabilitation services also include the professional services of physical therapy, occupational therapy, speech pathology and audiology, social work, clinical psychology, rehabilitation nursing, and prosthetics and orthotics.

The cost per case for patients requiring rehabilitation is substantial. Total charges for rehabilitation hospitalization alone average about $15,000 with non-Medicare patients charges higher than Medicare patients by perhaps 25%. The cost increases by another $3,000 to $4,000 when acute hospitalization charges are added. The average initial length of a rehabilitation stay is about 30 days. However, both the length of stay and the charges vary substantially by type of disability. The average rehabilitation length of stay and charge for spinal cord injury and head injury are 48/$20, 760 and 46/$21/140 respectively. Obviously, these data also vary depending upon the degree of disabling condition and there is substantial variance within most conditions.

Clearly, hospitalization charges are only part of total patient charges since physician services are intensive during and after hospitalization, and home care and outpatient care are often heavily utilized. Usually, daily physician visits are involved when a patient is a rehabilitation inpatient and physician services are also necessary during outpatient care. In addition, forty (40%) percent of spinal cord injury cases and thirty (30%) percent of stroke cases are discharged from rehabilitation programs to home with a formal home care program. More probably need it.

Coverage of Rehabilitation Services

Rehabilitation coverage should be comprehensive and include physician services, rehabilitation nursing, physical therapy, occupational therapy, speech therapy, psychological services, medical social services and prosthetic and orthotic devices and services. Medicare currently covers all of these services when provided to hospital inpatients and in outpatiet rehabilitation facilities. These services should be available in both a hospital setting and on an outpatient basis. Most are covered under Medicare in a home health setting. They should also be available in a skilled nursing home setting, though the intensity of the services will be less than in an inpatient hospital setting. For example, under Medicare, a patient is an appropriate rehabilitation hospital inpatient only if he or she needs three hours or more of physical or occupational therapy, close medical supervision and 24-hour rehabilitation nursing services. In th SNF setting, a much lesser level of therapy is provided, only one physician visit per week is covered, and full time rehabilitation nursing is not required.

We believe that the coverage of rehabilitation services should not be limited by numbers of days, services or visits but by requirements of medical need.

The Impact of Catastrophic Illness and Coverage Needs

The impact of catastrophic health insurance legislation on our patients and we professionals who serve them could be extraordinarily significant. Our patients need substantial hospitalization coverage (ALOS acute of 7-10 days plus ALOS in a rehabilitation inpatient hospital program of 25 to 30 days), S.N.F. services, physician visits on a daily basis in a rehabilitation hospital setting and often other physician services, comprehensive rehabilitation outpatient care including home care, and often homemaker health aide, respite care, adult day care or institutional long term care services. The question is : Is the coverage being considered adequate to meet the catastrophic needs of our patients? If not, are we all in the process of misleading the public, particularly the aged and disabled, by promising coverage for catastrophes but only covering a limited, though important amount of out of pocket expense for current Medicare deductibles and coinsurance.

Th following principles are ones we would suggest to guide you as you legislate on this important matter affecting many millions of Americans:

1. In focusing on catastrophic care needs, focus upon the importance of the severity of a person's disability, regardless of age and income and the likely duration of that disability. Disabling stroke, arthritis or multiple sclerosis can be severe and can last years. Sometimes the cost in one year is not extraordinary, but the cost in dollars and function over a lifetime is. Also, services have got to be covered and adequately paid for which include appropriate rehabilitation services for these disabling conditions and seek to minimize the disability. This is preventive care in reality.

2. Be clear as to what will be covered and what will not. Standards of disclosure, or "Truth in Advertising", should be adopted for all programs impacting on catastrophic illness. Medi-Gap standards may need to be revised, for example and standards regarding HMO coverage are needed. Many of our patients have no conception of how limited their coverage is until they become chronically ill and find that many of their health needs are unmet by insurance. The result is often uncompensated care which is adversely impacting many hospitals.

3. Make sure existing benefits relevant to chronic illness and disability are accessible to the aged and disabled who need them. Current rehabilitation related benefits are not uniformly available notwithstanding the fact that Medicare is a national program and that suppliers of care are available. Current rehabilitation benefits include physician services, physical, occupational and speech therapy, rehabilitation nursing services, social work and psychological services. Physician hospital visits to patients are limited to 3 a week by some carriers whereas we believe a hospitalized patient should be visited each day. Outpatient physical therapy visits are limited by some carriers to 6 a month but are not limited, as long as certified as necessary, by others. Rehabilitative home care benefits are limited by some carriers to 3 a week using the "intermittency" test. While Medicare abuse needs to be recognized, it represents only a small fraction of cases and the PRO system can deter those. Intermediary and carrier pre service limitation such as those mentioned are counterproductive and should be eliminated or at least be subject to national scrutiny through rulemaking by HCFA.

4. Again, with respect to Medicare and the disabled, we urge you to re-visit the question of the two year Medicare waiting period which a disabled person must endure after being determined to be eligible for Social Security disability benefits. As recent HCFA research shows, the need for coverage is greatest in that two year period and yet many of the disabled are uncovered by other insurance. Death rates in this waiting period are very high. In 1972, 35% of disability beneficiaries had no health insurance coverage in that 2 year period. While employer mandates in recent amendments and other factors have reduced that percentage, the problem is still serious. The majority view in the Report of the Advisory Council on Health Insurance for the Disabled (1969) recommended only a 3 month waiting period and the minority report a 12 month waiting period.

It is truly a catastrophe to have no coverage and a severely disabling illness. We would urge some combination of at least a reduced waiting period, further employer mandates and federal legislation stimulating state risk pools to deal with this issue.

5. With respect to all HMO programs, capitation formulas must be revised to take into account the disability status of functional limitations of enrollees. Until such changes are made, HMO's generally have little incentive to provide truly comprehensive services to the chronically ill and disabled. HMO's, and their experimental counterparts social H.M.O.'s, could be very relevant to catastrophic illness problems, but changes in payment formulas and in benefit representation are needed

6. Health and social services necessary to enable the chronically ill and disabled to function as independently as possible need to be covered and available for all populations with catastrophic illness as we define it. Such services are very important parts of comprehensive rehabilitation plans of care for chronically ill and disabled patients. Necessary services may include medical rehabilitation services necessary to maintain function; adult day care; homemaker and home health services; respite care and institutional nursing home services. The mechanisms to assure these services and others for all populations in need may vary including: (1) the use of private insurance with appropriate standards for disclosure of benefits covered and not covered; (2) reform of Medicaid services to include a possible Medicaid buy in and fee schedules for those able to pay something; (3) Medicare expansion.

While we support personal responsibility and private sector initiatives to assist in dealing with these many problems of catastrophic illness, we also believe that society benefits morally and materially from the provision of health care services to those who need them to function and who cannot afford them.

We commend you for your efforts and wish to be of assistance to you in this critical effort.

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STATEMENT OF GARY SHORB, PRESIDENT, REGIONAL MEDICAL CENTER AT MEMPHIS, ON BEHALF OF NATIONAL ASSOCIATION OF PUBLIC HOSPITALS

Mr. SHORB. Thank you, Mr. Chairman.

I am president of the Regional Medical Center at Memphis, locally known as the "Med." We are a 450-bed public institution. Last year, we had 21,573 inpatient admissions, over 60,000 emergency room visits, and 18,000 OB visits, and nearly 100,000 outpatient visits. We employed 2400 persons. I am also testifying this morning on behalf of the National Association of Public Hospitals. NAPH consists of 75 public hospitals and hospital systems that serve as major referral centers, teaching hospitals and hospitals of last resort for the poor in most of our nation's largest metropolitan areas.

Like most public hospitals in metropolitan areas, the Med offers numerous specialized inpatient services which, by their nature, attract catastrophically ill patients. We boast the most advanced trauma center in our region, the Elvis Presley Memorial Trauma Center. Our burn unit handles the most severe cases within a 150-mile radius of Memphis. Our high risk obstetrics center delivers half of all babies born in Shelby County each year, and we also operate an 80 bassinette, neo-natal intensive care unit, one of the largest and busiest such units in the world.

In 1986, our average occupancy rate was 86 percent, but this does not tell the whole story. When our occupancy reaches these proportions, we have to divert privately insured patients to other hospitals when the needed inpatient service is full.

The payer mix at the Med tells an important part of our story. Fifty-one point 4 (51.4) percent of all patient charges in 1986 stem from treatment of indigent patients. Another 23.2 percent of patient charges were allowable to Medicaid patients and 10.8 percent to Medicare beneficiaries. Only 14.5 percent of the total patient charges at the Med in 1986 were attributable to privately insured patients. Our total write off for bad debt and charity last year topped $76.9 million, of which Shelby County annual appropriations covered $26.8 million.

My testimony this morning centers around a simple but crucial economic fact. Although routine cases are a significant part of the economic burden of serving the uninsured patient, a single uninsured catastrophic patient can cause more budgetary harm to our public hospital than the large numbers of uninsured patients we treat who have more routine need.

Of the $76.9 million in total bad debt and charity care written off by the Med in 1986, a mere 7 percent of our indigent patients accounted for 26 percent of the total.

Let me give you some idea of the dollar impact of catastrophic illness or injuries at the Med. In fiscal year 1986, 22 percent of the admissions to our trauma unit resulted in bills totaling $10,000.00 or more. And, more importantly, of the 587 persons admitted to trauma whose bills were over $10,000.00, 55 percent were indigent. The figures for our burn unit were very similar.

It may be helpful to the committee to describe the scope of this problem in human terms. Consider the following stories of just a few of the thousands of catastrophically ill patients we work with each year. Mark Clodfelter had moved to Tennessee only recently and had already found part-time work when the front tire of the car in which he was riding blew, throwing the car and its occupants off a bridge. He was taken to a local hospital, but his injuries were too severe to be treated there, so he was flown by helicopter to the Med's trauma unit. Five months and five surgeries later, he was still at the Med. At age 22, as a part-time worker, he did not have insurance and could not afford to purchase it on his own. Even if he qualifies for Social Security, the Med will not be paid for his care, because benefits are not retroactive.

George Thompson worked before he fell ill with cancer, but not the kind of jobs that come with health insurance. Because his family income is greater than $153.00 per month, he is not eligible for Medicaid. Now he needs a prescription that costs $200.00 a month. The Med staff went to five different organizations that offer one-time voluntary donations, but none could help. In the end, the Med pharmacy is providing the drugs.

I have attached to my testimony today a more complete story of each of these unlucky individuals and others from the Med's 1986 annual report of which we have copies available for committee members.

We recognize the substantial nationwide improvements in health insurance coverage are likely to be costly budget items, and that incremental changes are therefore likely to be the best we can hope for in the short-term. For this reason it is doubly important that your committee continues to recognize that the Med and other disproportionate share hospitals will continue by default to serve as this country's national health insurance for those patients who fall through the cracks.

Finally, it is not at all clear what kind of changes in Medicare reimbursement to institutions are intended by these proposals in the context of the DRG-based PPS system. How will the increase in covered costs or the proposed Medicare catastrophic care provisions increase payments to hospitals? We strongly urge the committee to address these concerns in considering the Administration Medicare proposal. We have additional recommendations within our testimony.

Thank you.

Senator DASCHLE. Thank you, Mr. Shorb.

Dr. Stibbards?

[The prepared written statement of Mr. Shorb follows:]

NATIONAL ASSOCIATION OF PUBLIC HOSPITALS 1436 Twenty-First Street, N.W., Suite 10, Washington, D.C. 20036 (202) 861-0434

Denver General Hospital
Boston City Hospital
District of Columbia General Hospital
Harris County Hospital District (Houston)
University of Medicine and Dentistry of New Jersey University Hospital
Grady Memorial Hospital (Atlanta)
Cleveland Metropolitan General Hospital
Santa Clara Valley Medical Center (San Jose)
The Los Angeles County Hospitals
Parkland Memorial Hospital (Dallas)
Truman Medical Center (Kansas City)
San Francisco General Hospital
Bellevue Hospital Center
Bronx Municipal Hospital
Cook County Hospital
Contra Costa County Health Services Department
Brackenridge Hospital (Austin)
Wishard Memorial Hospital (Indianapolis)
Chope Community Hospital (San Mateo)
Worcester City Hospital
Alameda County Health Care Services Agency (Oakland)
Westchester County Medical Center
Milwaukee County Medical Complex
Nassau County Medical Center
Regional Medical Center at Memphis
Pacific Medical Center (Seattle)
University of New Mexico Hospital
Harborview Medical Center, University of Washington
Fresno County Valley Medical Center
General Hospital, Ventura County
R.E. Thomason General Hospital (El Paso)
Kern Medical Center (Bakersfield)
University of Cincinnati Hospital
University of Texas Medical Branch
Queens Hospital Center
Hurley Medical Center (Flint)
San Bernardino County Medical Center
San Joaquin General Hospital (Stockton)
Riverside General Hospital, University Medical Center
Oregon Health Sciences University Hospital
Spartanburg General Hospital (Spartanburg, SC)
Harlem Hospital Center
Charity Hospital of Louisiana
Maricopa Medical Center (Phoenix)
St. Louis County Hospital
Memorial Medical Center (Savannah, GA)
Amarillo Hospital District
Jackson Memorial Hospital (Miami)
Pontiac General Hospital (Pontiac, MI)
Clinton Memorial Hospital (Wilmington, OH)
Earl K. Long Memorial Hospital (Baton Rouge)

STATEMENT OF GARY SHORB
President
Regional Medical Center at Memphis

ON BEHALF OF

THE NATIONAL ASSOCIATION OF PUBLIC HOSPITALS

Senate Finance Committee
Hearing on Catastrophic Health Insurance
March 19, 1987

Mr. Chairman, Members of the Committee, I am Gary Shorb, President of the Regional Medical Center at Memphis, known locally as "The Med." We are a 450 bed public institution; last year we had 21,573 inpatient admissions, over 60,000 emergency room visits, and over 250,000 outpatient visits. We employ 2400 persons. I am also testifying this morning on behalf of the National Association of Public Hospitals. NAPH consists of 75 public hospitals and hospital systems that serve as major referral centers, teaching hospitals, and hospitals of last resort for the poor in most of our Nation's largest metropolitan areas.

In my testimony this morning, I would like to discuss three main topics: First, I will describe the impact on the Med and other NAPH member hospitals of providing catastrophic medical care for the elderly, disabled, and lower income individuals who are our primary patient population. Second, I will share with you some general observations on the Administration's Medicare catastrophic illness proposal, from the perspective of such hospitals. Third, I would like to offer you our assistance in addressing all of the significant health coverage gaps and unfilled medical needs of the American people, and in light of current budget concerns, offer suggestions for possible incremental or interim solutions to these important societal problems.

I. Catastrophic Care at The Med

Like most public hospitals in metropolitan areas, the Med offers numerous specialized inpatient services which, by their nature, attract catastrophically ill patients. We boast the most advanced trauma center in our region, the Elvis Presley Memorial Trauma Center. Our burn unit handles the most severe cases within a 150 mile radius of Memphis. Our high risk obstetrics center delivers half of all babies born in Shelby county each year, and we also operate an 80 bassinet neonatal intensive care unit, one of the largest and busiest such units in the world.

In 1986, our average occupany rate was 86%, but this does not tell the whole story. The Med was at or above 100% occupancy many times during 1986. During a majority of the days in June, July, and August of 1986, between 2 and 8 of our units were at 100% occupancy. Our mission of serving the indigent erodes our small but critical private pay base when our occupancy reaches these proportions, because we have to divert privately insured patients to other hospitals when the needed inpatient service is full.

The payor mix at the Med tells an important part of our story. 51.4% of all patient charges in 1986 stemmed from treatment of indigent patients. Another 23.2% of patient charges were allocable to Medicaid patients, and 10.8% to Medicare beneficiaries. Only 14.5% of the total patient charges at the Med in 1986 were attributable to privately insured patients. Our total write-off for bad debt and charity care last year topped $76.9 million, of which Shelby County annual appropriations covered only $26.8 million. We provided 52,275 days of patient care to indigent persons in FY 1986, and 81,929 outpatient visits.

My testimony this morning centers around a simple but crucial economic fact: although routine cases are a significant part of the economic burden of serving the uninsured patient, a single uninsured catastrophic patient can cause more budgetary harm to our public hospital than the large numbers of uninsured persons we treat who have more routine needs. Of the $76.9 million in total bad debt and charity care written off by the Med in 1986, a mere 7% of our indigent patients accounted for 26% of the total.

Let me give you some idea of the dollar impact of catastrophic illness or injuries on the Med. In FY 1986, 22% of the admissions to our trauma unit resulted in bills totalling over $10,000, and 11.8% of our trauma admissions cost over $20,000. Of the 587 persons admitted to trauma whose bills were over $10,000, 55% were in the indigent/self-pay category. On average, over

90% of our bills in the self-pay category become bad debt. Indigent/self-pay costs totalled over $11.5 million in our trauma unit alone; over $10.6 million of that sum, or 92% of the write-offs from our trauma unit, represented bills of over $10,000. Over $8.2 million, or 71.5% of these write-offs, represented bills of over $20,000. Every Medicaid patient admitted to our trauma unit generated a bill of over $10,000. The Med was reimbursed for less than half the costs of treating these Medicaid beneficiaries in our trauma unit.

The figures for our burn unit were similar. 24% of the admissions to our burn unit were indigent patients. Of the $1,167,381 cost to the Med of treating these burn patients, nearly 99% represented bills of over $10,000. Of the total admissions to our burn unit in FY 1986, indigent and paying patients, 42.8% had bills of over $10,000.

It may be helpful to the Committee to describe the scope of this problem in human terms. Consider the following stories of just a few of the thousands of catastrophically ill patients we work with each year.

- Mark Clodfelter had moved to Tennessee only recently, and had already found part-time work when the front tire of the car in which he was riding blew, throwing the car and its occupants off a bridge. He was taken to a local hospital but his injuries were too severe to be treated there so he was flown by helicopter to The Med's trauma unit. Five months and five surgeries later, he was still at the Med. At age 22, as a part time worker, he did not have insurance and could not afford to purchase it on his own. Even if he qualifies for Social Security, The Med will not be paid for his care, because benefits are not retroactive.
- George Thompson worked before he fell ill with cancer, but not the kind of jobs that come with health insurance. Because his family income is greater than $153/month, he is not eligible for Medicaid. Now he needs a prescription that costs $200/month. The Med staff went to five different organizations that offer one-time voluntary donations, but none could help. In the end, The Med pharmacy is providing his drugs.
- Because Effie Jacobs could not afford medical care, she waited too long before coming to The Med for treatment; as a result, she lost her right eye. She is typical of indigent persons who, because they are not insured, wait until a medical problem has become nearly unbearable before seeking help. At that late stage, help is not only significantly more expensive, it may also simply be too late.

- A freak accident with a .22 sent Johnny Hurley to The Med by helicopter, only two days before he was scheduled to start a new job. When he was laid off his last job, he lost both his insurance and the means to buy insurance for himself and his wife. Today, Johnny Hurley is a 23 year old paraplegic who is not eligible for public assistance.

I have attached to my testimony today a more complete story of each of these unlucky individuals, and others, from the Med's 1986 Annual Report.

The Med — and the patients we serve — are far from unique among NAPH members. In addition to general inpatient and outpatient services, public hospitals provide essential specialty care in their communities without regard to the profitability of such services. For example, of six such specialty services identified by the Urban Institute in 1982 — coronary care units, neonatal ICUs, pediatric ICUs, burn, organized OPD, and psychiatry — public hospitals were more likely to have any or all of these services. NICUs, PICUs, and burn units were 2> - 3> times more likely to be found in public hospitals than in private factilities.

While urban public hospitals represent just 5% of the beds in the country, they provided 40% of the charity care nationally in 1982. These hospitals also provide almost twice as much Medicaid care as their private sector urban counterparts ($10 million versus $5.3 million during 1980). According to NAPH, AHA, and Urban Institute data, the predominant categories of patients served by NAPH member hospitals are Medicaid and the uninsured. For example, during 1984, NAPH members reported that, on average, they received no reimbursement, private or governmental, for fully 31% of their inpatient days (49,000) and 51% of their outpatient visits (130,000). Another 25% of their inpatient days and approximately the same proportion of their outpaitient visits were related to Medicaid patients.

Medicare, at 17% on average, is still a significant payor for urban public hospitals. While the proportion of Medicare patients may be lower in our hospitals, recent studies indicate that our Medicare patients tend to be older, poorer and sicker than average. For example, the emergency room is the front door of the Med, for Medicare as well as other patients; 76.6% of our patients are admitted through the emergency room. A recently completed study investigated emergency room care costs in the context of the Medicare change from cost-based to prospective payment (Munoz, et al, 1986). The research directly addressed one fundamental question in particular: are Medicare ER admissions in urban public hospitals more expensive than Medicare nonER admissions? Identifying surgical admissions to the eleven acute care hospitals of the New York City Health and Hospitals Corporation over an 18 month period, the study matched DRGs (ER vs. nonER) and reviewed cost per patient data for 26,564 cases. The public hospital information uncovered a dramatic pattern: 75.8% of all surgical admissions occurred in DRGs where ER admissions were more costly than nonER admissions, at an average of 125% higher.

II. Comments on Administration Proposal

We recognize that substantial nationwide improvements in health insurance coverage are likely to be costly budget items, and that incremental changes are therefore likely to be the best we can hope for in the short-term. For this reason, however, it is doubly important that your Committee continues to recognize that the Med and other "disproportionate share" hospitals will continue, by default, to serve as this country's "national health insurance" for those patients who fall through the cracks.

From our vantage point, while the Administration's Medicare catastrophic proposal would represent a modest improvement, it will be of limited value to our nation's safety net hospitals, for two reasons: it does not address the catastrophically ill uninsured person or Medicaid beneficiary, and it does not address the long-term care problems which all lower income catastrophically ill patients (including Medicare patients) represent for our safety net hospitals and our nation's health system. While we recognize that this proposal will assist the low income Medicare beneficiary whose unpaid bills might otherwise become bad debt, it is also true that Medicare now picks up at least part of these bad debts already.

On the other hand, the Administration proposal does not fully cover the health needs of a catastrophically ill patient. For example, lack of adequate coverage for post-hospital home care or a nursing home stay remains unaddressed. The so-called "long term care" portion of the Administration proposal is simply inadequate. "Education" and encouraging persons to purchase long term care policies do not help persons who cannot afford such policies. When nursing home beds cannot be found or home care is not adequately reimbursed but the patient needs some level of continuing care, the patient ends up staying in the hospital by default. Exacerbating this problem is the fact that often, for nonmedical social reasons, low income Medicare patients cannot always be discharged in a timely fashion.

Finally, it is not at all clear what kind of changes in Medicare reimbursement to institutions these proposals intend, in the context of the DRG-based PPS system. How will the increase in covered costs translate into increased payments to hospitals? We strongly urge the Committee to address these concerns in considering the Administration Medicare proposal.

IV. Additional Recommendations

The underinsured Medicare beneficiary is the smallest portion of the catastrophic illness problem for NAPH member hospitals. Rather, for the Med and other public institutions, the most serious catastrophic care problems stem from the Medicaid and uninsured populations. This situation has been exacerbated in recent years by the increase in the size of the medically indigent population, the well-documented decline in Medicaid coverage, and decreases in Medicare coverage of hospital costs in certain DRGs.

For this reason, NAPH and the Med have the following additional recommendations for incremental legislative reforms:

o First, we ask that you seriously consider adopting a direct grant program to provide additional support at least for disproportionate share hospitals which may be in financial distress. Continued deterioration of health coverage in our country requires some form of targeted institutional assistance, at least on an interim basis.

There has never been a program of direct federal aid to hospitals serving the poor, despite significant funding devoted to community health centers, mental health centers, drug abuse treatment programs, and other kinds of health care providers. In 1982, the House of Representatives did pass a specific authorization for such a program. Title C of HR 3021, the Health Care for the Unemployed Act of 1983, would have provided a grant program for public and private hospitals providing disproportionate health services to the unemployed. This bill passed the House, but not the Senate. I have attached a copy of this Title and its accompanying report language to my testimony today, and I suggest that you use it as a starting point for considering adoption of a new program this year. The simplest and most direct method available to fund such a program would be an additional formula-based allocation through the Medicare process to some or all of those hospitals you have already identified as being eligible for a disproportionate share hospital adjustment.

o Second, reimbursement for illness or injury in certain catastrophic diagnoses, such as for burn care or trauma victims, remains shamefully inadequate.

From July 1, 1984, through September 15, 1986, the Med was reimbursed only 35% of total trauma charges for Medicare patients (just $1,849,035 was reimbursed out of $5,327,213 in total charges). We propose that the relevant rates for those DRGs be adjusted to reflect actual severity.

o Third, we strongly urge you to consider changes in the Medicaid program that also reflect the problems faced by more seriously ill Medicaid recipients and the hospitals that serve them. We would like to see this Committee give some thought to enforcing stricter standards for state Medicaid agencies in areas such as minimum eligibility levels and the mandated Medicaid disproportionate share adjustment.

Since OBRA of 1981 eliminated the link between Medicaid hospital reimbursement and Medicare payment principles, no state has used that flexibility to increase its Medicaid payments to hospitals. Many states, like Tennessee, have capped the number of days of care they will reimburse, thereby guaranteeing that catastrophic cases will not be covered. In addition, fewer than half of the states have adopted any meaningful payment mechanisms for disproportionate share hospitals.

A very current issue in Tennessee is the extent to which local government or local hospital groups can help finance improvements in their Medicaid programs. We would like to see this Committee permit the use of local funds to contribute to the State's Medicaid match to provide federally-eligible coverage the State refuses otherwise to fund. In Tennessee, we have already put together a consortium of public and private hospitals interested in expanding both eligibility and the services provided to Medicaid beneficiaries, and we are also willing to take a financial risk in doing so. This Committee could provide welcome federal support for our efforts. Consider, for example, an experimental waiver of the state-wideness requirement for local initiatives through which hospitals willing to invest in expanding their Medicaid programs can reap the full rewards of their efforts.

o Fourth, why not extend the basic concept of catastrophic insurance to the uninsured indigent? Even with a very high deductible, say $4-5000, public hospitals could be at least partially insulated from the kind of catastrophic financial burdens to which we are routinely subject by virtue of our mission.

At least in Memphis, our consortium would also be prepared to share the cost of this program with the federal government, if needed, and to work with you to develop a multifaceted approach that includes incentives to employers of uninsured low-income wage earners.

o Fifth, we believe it is also necessary to address the problems of Medicaid and low income uninsured hospital patients for whom long-term care beds are not available.

At the present time, a Congressionally mandated study of the "administratively necessary days" issue is underway. We suggest that this Committee consider the special needs of low income patients, and the difficulty in placing them into post-acute care institutions, by improving and insisting on enforcement of special rules you first enacted back in OBRA of 1981 to reimburse for these unavoidable inpatient days.

o Sixth, I would like to conclude with some brief observations about the possible impact on the Med and other NAPH member hospitals of several additional issues: the Medicare capital pass-through, continuation of the Medicare disproportionate share hospital adjustment, and the exemption of some of the hospitals receiving that adjustment from the repeal of PIP.

With regard to capital, our nation's urban public hospitals on average experience the lowest proportional Medicare "pass-through" payments of any segment of the hospital industry — under 4% by most standards, compared with over 7% for the industry as a whole. Many public hospitals would therefore potentially gain from a rapid phasing of capital payments into overall PPS payments. However, we do not support such a move at the present time. Nor do we support a long-term phase-in of capital payments, with or without "grandfathering" of old capital. Any of these proposals would divide the haves from the have-nots even among public hospitals. Rather, the most equitable approach is to leave Medicare capital payments the way they are now.

Finally, I wish to emphasize that we rely heavily on the protections the Congress has afforded us in recent years. The disproportionate share adjustments passed in 1986, the direct and indirect teaching adjustments, and the exemption from repeal of PIP for some disproportionate share providers, are quite simply essential to our future survival. It is imperative that these protections be preserved at their present level.

I would be happy to answer any questions you may have.

STATEMENT OF J.E. STIBBARDS, PH.D., CHILDREN'S HOSPITAL OF BUFFALO, BUFFALO, NY, AND CHAIRMAN, BOARD OF TRUSTEES, NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS AND RELATED INSTITUTIONS

Dr. **Stibbards.** Thank you, Mr. Chairman.

I am Ted Stibbards, chairman of the board of the National Association of Children's Hospitals and Related Institutions and also president of the Children's Hospital of Buffalo.

We have submitted for the record a detailed statement.

On the way here this morning I saw a license plate that said, "Ask me about my grandchildren." And I think that probably shows the affinity of the elder citizens of our country with our children and it makes it appropriate for us to be here today.

Speaking to Senator Durenberger's earlier comment, our proposal has the potential for future savings in health care costs through prudent and modest investment today in our children. With the chairman's approval, I would submit for the record a schedule of nine patients treated in one of our children's hospitals, each of whom had one to seven admissions with total cost from $133,000 to $1.1 million each. These nine cases total $5.2 million. Insurance companies and public programs paid for $2.7 million, leaving families and providers to cope with the charges of $2.5 million.

One case stands out. A child with a multitude of series medical problems also had a serious problem in renal failure. The primary insurer and Medicare met the cost of this care in total. Thus, one family, though burdened by severe illness of a child, was not destroyed economically by the financial burden accompanying it. Yet, only 2,000 children with end stage renal disease are protected under any element of the Medicare program.

[The information follows:]

9 Catastrophic Illness Cases in a Children's Hospital
Presented by the National Association of Children's Hospitals and Related Institutions

	All Admissions	Total Bill	Source	Amt. Collectible	Difference
AMANDA	7 Admissions	$1,119,255.13	Ins. Co. A	$500,000.00	
	12/22/84 - Present		Ins. Co. B	$395,419.13	
			Title 19	$ 20,665.00	$ 203,171.00
Skull/facial and extremity malformations, chronic lung disease (bronchopulmonary dysplasia = BPD).					
HILIARY	6 Admissions	$ 230,274.24	HMO A	$158,898.91	
	8/5/86 - Present		Title 19	8,348.00	$ 63,027.33
Hemorrhage into brain.					
DUSTIN	2 Admissions 12/28/85 - Present	$1,052,856.56	Ins. Co. C	$246,949.00	$ 805,907.56
Bronchopulmonary dysplasia					
JERRY	1 Admission 10/13/86 - 12/24/86 (Died)	$ 133,105.81	Title 19	$ 4,133.00	$ 128,972.81
Prematurity anoxic brain damage.					
ANDREW	1 Admission 10/26/86 - Present	$ 329,844.16	Ins. Co. D	$257,923.00	$ 71,921.16
Heart not covered with bony thorax.					
MARKEL	1 Admission				
	8/25/86 - Present	$ 355,598.25	Title 19	$ 4,174.00	$ 351,424.25
Joint contractures of fingers, knees, hips, elbows, ankles.					
CONNIE	1 Admission 9/21/86 - Expired	$ 317,057.30	Ins. Co. F	$224,079.00	$ 92,978.30
Severe malformations of colon, rectum, abdominal wall, pelvis and bladder					
DANIEL	1 Admission	$ 896,603.13	HMO B	$558,737.09	
	12/19/85 - 12/6/86 (Died)		Medicare	$337,866.04	$ -0-
Polycystic kidney with chronic renal failure.					
JOSEPH	1 Admission 1/9/86 - 12/5/86 (Expired)	$ 766,050.12	Title 19	$ 4,133.00	$ 761,917.12
Umbilical hernia atresia & stenosis of large intestine, anomaly of genital organs, anomaly of musculoskeletal system, patent ductus arteriosus					
	TOTALS	$5,200,644.70		$2,721,325.17	$2,479,319.53

Other families face catastrophic illness expense of a child from a number of causes. Fortunately, the incidents of such exposure is much lower than that of older Americans, but for a family, a child's illness or injury can be just as catastrophic as that of the grandparent.

A recent NACHRI study shows that out of 85,000 children's hospitals cases, only 1.35 percent had charges of $50,000. Yet, these cases accounted for over 26 percent of the total charges for all 85,000 admissions.

The average charges for these catastrophic expense cases was $105,000, and the average length of hospitalization was about three months.

Fifty percent of these patients were new-born babies. Some are premature, needing intensive care for several months until they learn to breathe on their own and grow to a normal weight. Others are babies with birth defects, requiring surgery and special care. Many of these babies will need continuing care to achieve their full potential.

And these hospitals also see children with serious chronic conditions who suffer periodic acute episodes, no one of which may be catastrophic in cost but which collectively and on an ongoing basis erodes severely the financial status of the families. Cystic fibrosis, muscular dystrophy, cerebral palsy are some such conditions which are seen.

Dr. STIBBARDS. Mr. Chairman, there is no single program for children equivalent to Medicare for the elderly to which improvements to deal with the catastrophic illness expense can be appended. It will require a number of private and public initiatives to protect the families of children from catastrophic financial disaster.

Fortunately, the overall number of children is low, and the cost of their protection, when spread over the entire population, will be similarly low. Of 3.5 million annual births, for example, all but an estimated 220,000 are routine and normal.

I will briefly summarize our statement's recommendation for the committee's consideration, several of which are pertinent to this committee.

One, require that all employers provide minimum health benefits for employees, including prenatal care;

Two, establish State-level insurance pools for individuals or those unable to obtain reasonably-priced insurance;

Three, allow employers to deduct costs of employer health benefits for tax purposes only if catastrophic protection is provided;

Four, tax employees on their health insurance benefits unless they cover their dependents. Alternatively, reduce their standard dependent exemption;

Five, protect the poor and near poor through mandated comprehensive expansion of the Medicaid program;

And, six, require that savings to Medicaid resulting from changes in Medicare be redirected within the Medicaid program.

This latter one is particularly important as any change in Medicare can reduce the amount of Medicaid dollars that are required.

Mr. Chairman, the children's hospitals will contribute to these efforts by continuing and intensifying their efforts to deliver high quality cost effective care, not just in hospitals but in the most appropriate setting.

Thank you for the opportunity to present our views on this most important needs for the American children and families.

Senator Daschle. Thank you, Dr. Stibbards, for an excellent statement.

Miss Nash?

[The prepared written statement of Dr. Stibbards follows:]

nachri **An Association Statement**

STATEMENT OF THE
NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS
AND RELATED INSTITUTIONS
BEFORE THE
COMMITTEE ON FINANCE
OF THE U.S. SENATE
ON
CATASTROPHIC HEALTH INSURANCE

March 19, 1987

The National Association of Children's Hospitals and Related Institutions is a voluntary association dedicated to promoting the health and well-being of children. NACHRI is the only national organization of children's hospitals in the country. It represents 94 children's hospitals. All are nonprofit. Virtually all are teaching hospitals. Many are committed to research. All are deeply involved with the communities they serve and generous with charitable care.

For children's hospitals and the families they serve, catastrophic illness is the major legislative issue.

The report of Secretary of Health and Human Services Otis R. Bowen, requested by the President, acknowledged that catastrophic illness expense touches all segments of society. The Secretary's specific legislative proposal now endorsed by President Reagan, is limited to the elderly. It would enhance Medicare's Part B to prevent annual out-of-pocket expense of more than $2000 for Medicare covered services. Children with catastrophic illness expense are served in very

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limited numbers by Medicare through the End Stage Renal Disease program, which provides a predictable flow of resources to families to meet the costs of treatment. While enhancing Medicare coverage would undoubtedly assist the 2000 families whose chldren suffer from this condition, it would not alleviate the burdens faced by thousands of others.

For a family, any child's illness or injury can be just as catastrophic as that of a grandparent. To a family without resources to provide adequate care for a child, health care expenses are catastrophic. Although this happens primarily among families who are uninsured, underinsured, or uninsurable, no one is immune from illness expense of catastrophic proportions. High technology care now available where previously no treatment was possible, can bring with it high costs and the dilemma of payment to those whose resources are sufficient for routine and anticipated services.

DEFINING "CATASTROHPIC ILLNESS EXPENSE"

The threshold of "catastrophe" is relative to those resources which can be dedicated to illness expense without severe and lasting effect on living standards or other essential needs. For the elderly, protecting against catastrophe often focuses on maintaining living standards or guarding static resources needed for future living expenses. A young family is more concerned with building for the future, saving for education, or progressing toward a higher living standard. Catastrophe in this case threatens the stability of the family's current economic status and achievement of future goals.

Financial catastrophe may have several levels. Where a family's resources are severely limited, even minor events will result in financial catastrophe. As available resources increase, the threshold of financial catastrophe also increases. Yet there is always the potential for a serious or lasting erosion of the family's standard of living.

Of course catastrophe is not simply a financial concept. The stress of a child's illness or injury places emotional and social burdens on the entire family. A parent may have to cease working, leading to a decreased family income during a period of increased resource needs, with resultant stress. Siblings suffer from loss of parental attention and deprivation from the economic sacrifices imposed, such as loss of savings for higher education. As a whole, the family suffers from disruption of a stable and predictable family life-style. These emotional and social stresses affect families of all economic levels, though those with more adequate means or other support systems will absorb the shock better than others.

Catastrophic illness expenses in the pediatric population may derive from one or more of three sets of circumstances:

- Acute care needs which are sudden and episodic in nature:
  - Approximately 220,000 premature babies are born each year; with intensive care nursery charges approximately $1,000/day, average hospital charges are over $35,000 for an immature infant
  - Heart surgery for a child may cost a family $22,000 for a hospital stay
  - Treatment for extensive burns may result in a hospital bill of $45,000
- Chronic care needs which are on-going, have a cummulative effect, and are likely to be coupled with spells of acute illness:
  - Comprehensive care for children with cystic fibrosis can cost a family $6,000 - $12,000 annually; intermittent hospitalizations may average over $7,000 per stay
  - Institutional care for a ventilator dependent child may amount to $350,000 annually
- Primary care needs which are catastrophic for those with no insurance or very limited resources, which prevent their being properly addressed:
  - Treatment for an episode of asthma may cost a family $600
  - Routine hospitalization may incur costs of $700/day

CATASTROPHIC ILLNESS EXPENSE IMPACT ON POPULATION SEGMENTS

Catastrophic expenses can befall all segments of the population. The extent to which a family will be faced with hardship will be determined to a great extent by the resources it has available to meet the need. Since health insurance is a prime resource, the scope of the catastrophic illness expense problem can be examined better by grouping the population by [illegible] of insurance protection:

- The uninsured, estimated to be some 35 million Americans who are without health insurance
- The underinsured, another 10 million who may have insurance part of the year, or who have very limited benefits
- The uninsurable, who, because of health status, cannot obtain health insurance at a price they can afford

The uninsured are people who are unemployed, or whose employment does not offer health benefits for employees and/or their children. Often these individuals are employed part-time or seasonally. Yet, 60 percent of the uninsured in America do work. Eight million of the uninsured are dependents of employed adults.

Some individuals, such as self-employed businessmen and farmers, do not qualify for group coverage and must depend on costly - often unaffordable - individual coverage for themselves and their families. Individual policies are apt to include clauses restricting coverage for specific diseases, exclusion of coverage for pre-existing conditions, and very high premiums.

Lack of insurance and other available resources for health care results in immediate barriers to access. Adults may lack access to basic primary and preventive care. Mothers may not have access to adequate prenatal care, resulting in severely impaired premature infants or failure-to-thrive infants. Such births may represent a relatively short-term crisis, perhaps three months of intensive care, or they may result in chronic disabilities requiring years of specialized care, frequently with episodes of acute needs.

Parents may lack resources to provide for a child's short-term acute episodes of illness, such as asthma and ear infections. Left untreated, acute episodes may lead to serious, chronic, and disabling conditions.

Even when resourced to meet basic needs, a family may lack adequate protection for treatment of chronic conditions, rehabilitation, or the special support needed between acute episodes of a chronic condition.

Institutionalization may be mandated, despite preferences for and appropriateness of home care, in order for the family to receive public support.

MEDICAID AND CATASTROPHIC ILLNESS EXPENSE FOR THE POOR

Medicaid, the federal/state health care program for the poor and the major public program for child health, does not provide adequate coverage. In 1983, children under age 18 accounted for 38 percent of the poverty population. AFDC children were 44 percent of Medicaid recipients, but caused only 12 percent of Medicaid expenditures. In the same year, those over age 65 constituted 11 percent of the poverty population but were 16 percent of Medicaid recipients. In sum, the elderly, blind, and disabled accounted for 75 percent of Medicaid expenditures.

Medicaid is an inconsistent national resource. States have overly broad discretion in determining eligibility and services covered. The variability by state of Medicaid coverage makes the program inherently inequitable in its services, simply as a function of geography. For example, in 1984, eligibility income in Alabama was 17 percent of the federal poverty level, while in California it was 74 percent. In that year, the poverty level for a family of four was $10,200. Overall, the average eligibility income in 1984 was only 38 percent of the federal poverty level.

States also are authorized to impose limits on services, including mandated services, within established guidelines. For example, in 1984:

- fifteen states imposed limits on the number of inpatient hospital days per spell of illness, ranging from 10 to 45 days
- fifteen states limited coverage for specific procedures
- twelve states limited the number of outpatient hospital services/visits per year
- fifteen states required prior authorization for certain services or procedures; and
- six states limited psychiatric services

Where coverage is limited by scope of services or eligibility levels, care often is delivered by the provider without compensation, which may mean that the provider cannot adequately or consistently support comprehensive services for all those in need. Further, changes in the health care marketplace make it increasingly difficult to transfer the cost of care of those who cannot pay to those who can.

States have the option to provide a Medically Needy Program, in which individuals can become eligible for coverage based on the amount of their incurred medical expenses. However, to date only 34 states have adopted this option. Again, within the Medically Needy Program, states control eligibility through levels of projected income, allowable resources, and length of time during which persons must spend down their resources. Even the Medically Needy option is lacking, with eligibility on average reaching only 51 percent of the federal poverty level.

FAMILIES ABOVE THE POVERTY LEVEL

People who are "near poor" and "middle class" often are underinsured. The economy is increasingly service-based, with large numbers of unskilled or semi-skilled part-time employees. Between 1979 and 1984, 60 percent of newly created jobs paid less than $7000 annually. Employers are not required to provide benefits for employees, or their dependents. There is no substantial incentive, such as a tax benefit, to encourage employees to select comprehensive health coverage for their children.

While more recent aggregate data are not available, the 1977 National Medical Care Expenditures Survey (NMCES) data show:

- Sixteen percent of poor children are always uninsured, despite the head of household being employed
- Only 70 percent of all children under age 18 are covered by private insurance all year
- Of those children with private health insurance, only 83 percent have major medical coverage, and less than ten percent have unlimited coverage

Even families with good incomes may face devastating costs with the illness of a child, especially if the need is for long-term care or treatment not covered by traditional insurance policies. A 1986-study by the United Cerebral Palsy

Association depicts the costs commonly associated with this chronic condition, and the amount borne by the family:

- For surgical procedures, private insurance pays up to 80 percent
- Expenses for wheelchairs, braces, and special adaptive devices represent a continual drain on family resources; the equipment purchased by many families is "dictated by availability of funds rather than...the need"
- Families usually bear the entire cost of making a home accessible to a handicapped child
- Special transportation costs are also met almost exclusively by families

Current expenses, including doctor bills, speech therapy, and medication average $4490 annually, with 51 percent paid by the family. Such families face the burden of continuing and accumulating health care costs which in sum, are catastrophic

The uninsurable population is comprised of individuals, both children and adults, whose health status precludes them from obtaining health and life insurance. This population is increasing as demographics demonstrate the gradual aging of America and the increasingly successful application of medical technology. People who previously died from serious diseases are now able to live with those diseases, yet often with a constant drain on their resources and exclusion based on medical history, from affordable insurance protection.

Approximately nine percent of Americans have a serious illness, and one to two percent of all children in America have a severe chronic illness. A 1986 study by Communicating for Agriculture shows that of rural Americans surveyed in five states over the past three years, 10 percent had been denied health insurance because of health status.

PRINCIPLES OF A POLICY FOR CHILDREN

A number of basic principles can be identified that guide recommendations for a solution to catastrophic illness expense for children:

- This issue is primarily one of equity and access to care for all children
  - Medical science has shown what can be achieved when children receive adequate preventive, palliative, and anticipatory services
  - Society responds positively in individual cases, such as when pleas are made to extend all that medicine can offer, as in the case of organ transplants
  - It is ethically unacceptable that care be available only to those with resources to pay
  - Society has deemed the elderly entitled to appropriate and necessary health care through the Medicare Program. To assure that the generations are not divided arbitrarily, children deserve the same consideration
- The issue is one of maintaining family integrity and stability
  - Care should be provided in the setting that maintains and encourages a stable family situation
  - When a child is ill, the whole family feels the impact, both socially and economically. A goal of public policy must be to ameliorate the economic disruption of the family, which is a leading cause of family disintegration
  - Public policy in welfare reform and education has stressed the importance of maintaining the fabric of the family. Health care policy deserves the same emphasis
- The issue encompasses more than high-technology, expensive care
  - Public policy must respond to the variety of situations that can be considered catastrophic. Primary care needs for the poor and chronic care needs must be met as well as the needs of the severely ill child
  - As the problem has no single cause, the solution will not come from a single resource. Public policy must draw on all facets of society, incorporating efforts by both the private and public sectors, and the family
- Safeguarding the health of children is an investment in the future
  - There is a compelling interest on the part of government to ensure the safety and well-being of children, so that future generations will be at least as stable and independent as the present

  - There is likely always to be a segment of society that cannot adequately provide for itself, and must turn to the public for assistance
  - We demonstrate our worth as a society by providing for those who are most in need--including those children who suffer from catastrophic illness expense
- The issue resolution must not overlook the current need to be budget-realistic
  - Public, congressional, and executive commitment to reduction of the federal deficit is clear

- Cost containment and quality assurance are essential components fo catastrophic care coverage. Clinical case management is a process that should be used to
  - Facilitate earliest possible discharge to the home environment
  - Coordinate the provision of quality ambulatory services at the lowest cost

PUBLIC AND PRIVATE INITIATIVES TO REACH CHILDREN IN NEED

Employment-related health insurance remains the dominant mechanism for protecting the working population. The association has identified a number of public policy initiatives to strengthen this resource, including:

- The requirement that all employers provide a minimum health benefits package for employees, including prenatal and child health care
- The development of state level insurance pools for participation by small employers, self-employed, and seasonally-employed people. Allow, if actuarially sound, uninsurable people to purchase from this pool; or
- The establishment, if necessary, of separate state risk pools for the uninsurable
- The development of state or regional catastrophic insurance pools where such coverage is not provided or cost effective for small employers or risk pools which include:
  - a full range of necessary institutional services for therapeutic purposes

  - home health care; including coverage for adaptive services, transportation and support services
- The encouragement of other insurance pools to buy into the catastrophic pool along with other beneficiaries to maximize risk-sharing
- The allowing of tax deductibility of employer paid health insurance premiums only with provision of catastrophic protection or their participation in the catastrophic insurance pool
- The taxation of employees on their health insurance benefits unless they cover their dependents; alternatively, disallow a portion of their standard deduction for dependents unless those dependents are included in their insurance benefit
- The protection of the poor and many of the near poor through comprehensive expansions in the Medicaid Program including:
  - mandating coverage for pregnant women and children under age six whose incomes are below the federal poverty level; and
  - eliminating state-to-state discrepancies with regard to eligibility and the extent of services provided
  - requiring that any savings to the states in the Medicaid program accruing from Medicare changes be maintained within Medicaid
- The inclusion of children in any demonstration project or study of catastrophic coverage
  - Secretary Bowen recommends a long-term care study for the elderly; this study should include children with long-term care needs
  - Secretary Bowen recommends a demonstration project of catastrophic benefits for Federal employees; such a demonstration should include children
- The initiation by the Federal Government of a new study of health care costs, utilization, and resources that includes children
  - Current aggregate, national data of this nature are lacking, with the NMCES study now ten years old.

STATEMENT OF DORIS NASH, PUBLIC AFFAIRS DIRECTOR, CANCER CARE, INC., NEW YORK, NY

Ms. NASH. I am Doris Nash, Public Affairs Director at a social work agency called Cancer Care. We have offices in New York, the metropolitan area, as well as several in New Jersey.

We think of ourselves as a very unique agency in that we are devoted to helping cancer patients and their families, and we give some of these patients money to help them maintain care-at-home plans or pay for transportation costs to and from therapy.

I see us as epitomizing the public-private relationship in that we postpone Medicaid applications and in many instances prevent them. We are giving monies to people with limited resources. If someone comes in and has a hundred thousand dollars in assets, we do not give any financial assistance. We do have our guidelines as to who will get help in that area and who will not.

We do not charge any fees. We raise all our own money and each year with greater difficulty, as I think you can appreciate.

We have done our work for over 42 years. And I am here to tell you that we know from this work that what really breaks the family's back is the home care costs for patients. These are patients who do not necessarily need nursing home care nor should they go into nursing home care nor do they want to. Their families are quite involved with them. The families help out as much as they can, but they still need help in paying for home care.

So we feel that any catastrophic plan that doesn't have coverage for home care—adequate coverage for home care—really—just doesn't meet the bill at all.

We have for years said that the skilled service requirements for eligibility for Medicare's home health care should be eliminated. And I have been with Cancer Care for 12 years, and 12 years ago there were bills in the hopper to eliminate that requirement. But just as national health insurance went out the window, so did that.

I would like to emphasize that all this fuss about a catastrophic health insurance proposal, while it does not give coverage for home care, and while it ignores what is happening on the home health care scene for the elderly right now, is really unrealistic and I am concerned that it is like a smoke screen actually.

What I am referring to here is the DRG system sending people home much, much earlier than ever before and with the assurance of getting less in the way of home health care if they get anything at all. Because of what Dr. Constant spoke to, the new definitions of what is part-time and what is intermittent and what is homebound, have so increased the number of denials of home health benefits that Congressman Staggers and others have instituted a suit against the Department of Health and Human Services on this issue.

People are going without the little bit of help at home that they got previously.

I know that what we are recommending is going to cost money. I would like to add to something that was said earlier—I think by Mr. Willging—that it is costing the government money already because Medicaid is paying for so much of the long-term care of patients.

I would like to bring up another phenomenon that I have gotten more and more aware of, and that is the number of middle class people who are stashing away their money in one way or another to get themselves ready for when their turn will come to need for long-term care. So they become eligible for Medicaid long before they really need it. And it is becoming, I think, more and more part of our mores. We now think it is all right to do this. I find it rather shocking. I find it shocking that I told a friend who had Parkinson's that he ought to give his money to his daughter because he would need care at home. And if you are in New York City, you are better off on Medicaid and you can get lots of care at home.

Luckily, his heart gave out before he needed that care at home. But I didn't like the role I played in this. It went against my grain. But that is happening more and more. And I would like to call that to your attention because it is costing the government.

Senator **Daschle**. I am not sure I share your view that it was lucky that he had his heart go out. But I understand the point you make and it is well taken.

Ms. **Nash**. Knowing this man, it was lucky.

Senator **Daschle**. Miss Miller?

[The prepared written statement of Ms. Nash follows:]

LEGISLATIVE MEMORANDUM

CancerCare, Inc.
AND THE NATIONAL CANCER CARE FOUNDATION INC.

WERNER WEINSTOCK
Chairman, Public Affairs Committee

JAN C. CHILDRESS
Vice Chairman, Public Affairs Committee

DORIS B. NASH
Public Affairs Director

March 19, 1987

To: Honorable Lloyd Bentsen, Chairman
Committee on Finance
United States Senate

Re: Coverage for Catastrophic Illness

We wish first to commend Senator Bentsen and the Committee on Finance for holding this hearing on the very important and urgent subject of coverage for catastrophic illness. It is crucial that there be public debate on the issue to help insure passage of an adequate plan for catastrophic coverage.

Cancer Care, Inc. is a voluntary social service agency which, for over 42 years, has offered comprehensive social services to cancer patients and their families. We have offices in New York City, Long Island and New Jersey and we are completely dependent upon contributions from the public and foundations. Our services include individual and group counseling, help with planning for the care of the patient, as well as some financial assistance to eligible families to help them meet the costs of home care plans and transportation to and from radiation or chemotherapy. We are also utilizing a special foundation grant in 3 boroughs of New York City to assist certain medically indigent patients with payments for cancer therapies. During our '85-'86 year, we served over 10,000 patients and disbursed more than $990,000, with most of the disbursements going to elderly patients. In the first 7 months of our current fiscal year we have assisted over 6300 patients and have disbursed nearly $640,000.

Since we deal on a daily basis with the dread and very often catastrophic illness of cancer, we are extremely knowledgeable about the many needs of these patients and the financial, practical, problems as well as the emotional problems, which confront them and their families. We feel that this expertise is translatable to other catastrophic illnesses which also frequently require a multitude of out-patient services.

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Many years ago our agency did a study of the illness-related costs experienced by many of its patients. We found then (1972) that the median cost was $19,054, while the median health insurance payment these families received were only $8,000. True, our definition of illness-related costs is a broad one. We include in our calculations all the special needs that are sparked by the patient's illness. Paramount among these are home health care, child care, housekeeping costs, transportation, and medication. While our definition may be broad, it is very realistic — the cost of illness cannot be measured just by hospital and physician charges.

A 1984 study of a sample of 404 of our patients reconfirmed the fact that so many of the patient's/families expenditures were related to out-patient costs. We were giving some financial assistance to over 1/3 of these patients and 26 percent of the patients had depleted 80 to 100 percent of their assets. Ninety of the patients reported that their monthly expenses had increased 40 to 79 percent as a result of the illness. The major reasons for these increases were special living costs due to the illness and out-patient medical costs.

For those with seemingly adequate health insurance coverage, an illness can still cause a catastrophe because of the "hidden" costs created by the illness. Thomas Hodgson, in an article on "Social and Economic Implications of Cancer in the United States" (Annals of the New York Academy of Science, Vol. 363, 1981), speaks to the need to study non-health sector direct costs, which he estimates may add another 5 to 25 percent to the total direct costs. The non-health sector direct costs he refers to are special diets and clothing, dwelling modifications, homemaker care.

Also, according to the NMCES study conducted by the National Center for Health Services Research and completed in September 1979, "A fifth of the nation's 80 million families incur catastrophic out-of-pocket medical expenses - costs that absorb an abnormally high percentage of their total income." (NCHSR Research Activities, May 1986, No. 85). Clearly the problem is very prevalent.

Our lengthy experience confirms that for the majority of cancer patients, inpatient care in a hospital is relatively minimal in comparison to the out-patient needs that are sparked by the illness. Therefore, we have long questioned the adequacy of any catastrophic coverage plan that is based merely on more comprehensive coverage for inpatient care. As a result, we have been critical of the President's and other proposals to ensure that Medicare patients will not be required to spend more than $2,000 a year for deductibles and co-insurance payments for hospital care.

For the great majority of the elderly, the cost of inpatient hospital care is the least of their worries, since most hospitalizations are short term and are covered by Medicare. While it is estimated that more than 200,000 elderly Americans each year experience hospital stays in excess of 60 days, this is indeed a very small segment of the many millions enrolled in Medicare — 29,284,396 as of February 1986. Further, the average length of hospital stays for patients over age 65 was only 8.9 days in 1984. Clearly the overwhelming majority of Medicare patients experience only short hospital stays.

While we certainly sympathize with the plight of those Medicare patients whose hospital stays exceed 60 days, or those who may need several hospitalizations in one year, singling them out for increased benefits does not compensate sufficiently for the other inadequacies in Medicare coverage. We must be just as concerned with those who are forced to spend great sums of money — sometimes pauperizing themselves — to secure adequate and sufficient home care services.

We must also be concerned with how much Medicare patients must spend for drugs. And, can we dare overlook Medicare's very inadequate coverage for long-term care — how to pay for nursing home care justifiably worries Medicare patients a great deal.

A very prolonged hospital stay is far from being the only definition of catastrophic illness. The definition must be broadened to include those illnesses which require extensive home or institutional care. These patients also deserve to be helped to acquire these services with dignity and without fear of impoverization.

We feel compelled to take this opportunity also to point out that while there has been a swing towards amending Medicare to completely cover hospital care, the DRG reimbursement system, designed to decrease health care costs, has led to earlier discharges from hospitals. Medicare patients are being sent home earlier in their illnesses than ever before. Simultaneously there have been cutbacks in the availability and intensity of Medicare's home health services. This has been accomplished by reinterpretations of the Medicare statute and the creation of new definitions.

We have long criticized Medicare because of its paucity of coverage for out-patient needs, and its stringent eligibility requirements for home health care: the patient must require a skilled service, must not need more than part-time or intermittent care and, in most instances, the patient's condition must be acute and short term. These rules governing home health care always eliminated a very large number of elderly cancer patients who may need daily care from a home health aide for a more protracted period of time, or, who may not need a skilled service at home in the first place.

Now, because of the new rules and regulations governing Medicare's home health services, even fewer patients are receiving assistance at home. This is a situation that must be addressed quickly, and we are pleased that Representative Staggers and 13 other congressmen have joined in a suit against the Department of Health and Human Services, challenging "the attempted dismantling of the Medicare home health benefit..." via "actions which are violating plantiff's rights under the Medicare statute, the Administrative Procedure Act and The United States Constitution." We are hopeful that this suit will at least restore Medicare's home health services program.

Any plan for coverage of catastrophic illness is incomplete unless it includes sufficient coverage for the care-at-home needs of patients. We can and do appreciate the possibility that opening up and broadening the home health benefit will sharply increase Medicare's expenditures for home health care. We can also appreciate that eligibility criteria would have to be carefully worked out and that adequate case management would be essential. But we must remember that ignoring the problem doesn't necessarily mean that government gets off the hook entirely.

Elderly patients who need long term home health services frequently end up depleting their resources, actually pauperizing themselves. This is called "spending down" in the language of Medicaid, the federal-state health care program for the very poor. The patient's care is then paid for by the government, at least in those states such as New York that have spend-down programs. Other elderly folk, having caught on to the system, turn their resources over to their children so as to be eligible for Medicaid in advance of their actual need for care. Thus, in many instances, government ends up paying for out-patient care, including home care, just as it does for the nursing home care of millions who may have started out by paying for this care themselves. Shouldn't government be willing to help the elderly with their realistic home care needs in such a way as to avoid reducing them to poverty or duplicity?

In closing, we want to reiterate our belief that adequate coverage for home care must be an integral part of a plan for a catastrophic health insurance. Only then can a catastrophic plan be truly meaningful.

STATEMENT OF CAMILLA M. MILLER, MEMBER, BOARD OF TRUSTEES, NATIONAL ALLIANCE FOR THE MENTALLY ILL, RICHMOND, VA, ON BEHALF OF NATIONAL ALLIANCE FOR THE MENTALLY ILL, AMERICAN PSYCHIATRIC ASSOCIATION AND NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS, ACCOMPANIED BY SHERVERT FRAZIER, M.D., MEDICAL DIRECTOR, MCLEAN HOSPITAL, BELMONT, MA

Ms. MILLER. Mr. Chairman and other distinguished Senators, my name is Camilla Miller. I am a member of the board of directors of the National Alliance for the Mentally Ill. I am before you on behalf of NAMI's 42,000 families of seriously mentally ill citizens across the country. I can't tell you how many more hidden families I represent, and you can be sure it is more than either you or I wish to think.

I am also speaking on behalf of the American Psychiatric Association, a medical specialty society representing over 33,000 physicians and the National Association of Private Psychiatric Hospitals, which represent over 250 nongovernmental private psychiatric hospitals.

With me is Dr. Shervert Frazier, formerly Director of the National Institute of Mental Health; currently medical director of McLean Hospital in Belmont, Massachusetts, and also a strong advocate for a greater federal investment in research, treatment and rehabilitation for our country's mentally ill citizenry.

Not with me today is my son. He is 29. He is good looking and he is talented, and he has schizophrenia. He is a living and breathing catastrophe.

You are here today to hear about catastrophic health coverage, the safety net that is supposed to catch my son if and when he falls. I am here to remind you that the Medicare program has not been changed in 22 years; that the $250.00 per annum allocated for outpatient care is a cruel joke.

Think for a moment of all you know about serious mental illness. You know it steals dreams. My son wanted to be an architect like his uncle, my brother. That will never happen. You know it comes, and it can stay, and stay, and stay. You know that it stays on. As it stays on, it cost huge sums of money to treat; that it can be treated, and that it is worth treating. And that we pour funds forth in hope of some remedy.

You also know that the current Medicare provisions are for 190 days of inpatient care in a psychiatric hospital for life. That is six months covered out of a life time with a catastrophic illness.

My son is 29, nearly 30. He has been ill for 13 years. That is 12 and a half years more than Medicare covered. And he is not well yet. He is doing much better, but he is not out of the woods. And neither are most of his peers.

Research has proven the existence of a genetic marker for Alzheimer's disease, for Down's syndrone and now manic depressive illnesses. Yet you continue to limit coverage for mental illness. Why?

I raised four children single-handedly. I worked a lot of overtime. A nurse's salary doesn't go very far under those circumstances. We went without because we had no choice. Today, we might have a choice.

Mr. Chairman, you and your colleagues are in a position to make a decision about the choices that countless families could have. Medical science has come a long way since 1965. We know so much more about the workings of medication and the value of rehabilitation programs. We think of whole spectrums of appropriate care settings, where once we knew of only one very sad option: long-term hospitalization.

In a moment I would like Dr. Frazier to share with you some of the recent advances science has made in the realm of psychiatric care. I think you will feel the excitement and the optimism these routes of inquiry provide to both of us, to me, who deal with mental illness, a catastrophic illness, day in and day out. In the face of these findings, I must ask you a single aching question. Why are we allowing ourselves to discriminate in public policy against mental disease, which we know today is indeed an organically-based disease? We are in a position to make a real difference for people who need every break they can get? Right now we are only compounding the catastrophe. I thank you.

Senator DASCHLE. Thank you, Miss Miller.

Dr. Frazier.

[The prepared written statement of Ms. Miller follows:]

STATEMENT

OF THE

NATIONAL ALLIANCE FOR THE MENTALLY ILL

AMERICAN PSYCHIATRIC ASSOCIATION

NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS

ON CATASTROPHIC INSURANCE COVERAGE

PRESENTED BY

CAMILLA M. MILLER, BOARD MEMBER
NATIONAL ALLIANCE FOR THE MENTALLY ILL

BEFORE THE

SENATE FINANCE COMMITTEE

MARCH 19, 1987

Mr. Chairman and other distinguished Senators, on behalf of the National Alliance for the Mentally Ill, representing 680 affiliate members nationwide and 45,000 family members of seriously mentally ill persons; the American Psychiatric Association, a medical specialty society representing over 33,000 physicians; and the National Association of Private Psychiatric hospitals, representing over 250 non-governmental private psychiatric hospitals nationwide, I am pleased to present our views regarding catastrophic health insurance for those with mental illness to the Senate Finance Committee. With me is Shervert Frazier, M.D., former Director of the National Institutes of Mental Health, and current Medical Director of McLean Hospital in Belmont, Massachusetts.

As the Finance Committee considers options for catastrophic illness protection, NAMI, APA, and NAPPH hope that you will carefully consider the mental health needs of our under 65 Medicare-eligible Americans as well as the over 65 population. Mr. Chairman, mental illness is like any other disease, it can be diagnosed, treated and can be costly both financially and in human terms. Mental illness is in some ways even more devastating than other diseases because both private insurance and federal Medicare and Medicaid programs do not adequately cover the costs of caring for the mentally ill. While catastrophic discussions have focused on acute care for physical illnesses, we should not forget to include chronic disabling diseases, such as schizophrenia or severe depression, in the catastrophic debate. These diseases are as catastrophic as any physical illness, and in many instances, much more catastrophic.

Our testimony today focuses on the extent of the need for mental health care; the cost-effectiveness of treatment of mental illness, discriminatory health insurance coverage for care of the mentally ill, and suggestions for improving psychiatric services under any catastrophic proposal.

Mental Illness and Addictive Disorders

According to the Institute of Medicine (IOM) report "Research on Mental and Addictive Disorders," 15% of the population suffers from serious mental disorders at any one time. During their lifetime an estimated 3 million people will develop schizophrenia. It is important to note that we are talking about the treatment of a disease -- mental illness -- not the health/happiness/achievement of potential/social welfare services. Treatments for mental illness may be as aggressive as many life saving techniques. Direct costs of mental illness were estimated to be $33.4 billion in 1983.

To be more specific about the biological nature of mental illness, within the past few years exciting new breakthroughs in the treatment of mental illness have significantly changed not only our understanding of the causes of mental disorders, but have also given us the ability to effectively treat such disorders. For example, through recent research we have attained the capacity to effectively treat more than 85% of all severe depressions using drugs and psychotherapies. We have verified the existence of a genetic component to psychoses, and determined that environmental events may trigger one's inherited risk or predisposition for a given disorder. We have also refined techniques for diagnosing mental illness, which permits treatments to be tailored specifically to a patient's needs and ensures comparability of results in clinical research. Finally, we have gained a capacity, through techniques such as positron emission tomography and nuclear magnetic resonance, to observe biochemical activity in the conscious brain, and define discrete areas of the brain that may be defective in certain illnesses. Although there have been tremendous advances in the diagnosis and treatment of mental illness in recent years, psychiatric benefits under Medicare and private insurance remain in the dark ages.

Mr Chairman, as you know, the elderly population is growing and will represent a larger proportion of the general population (20%) in thirty years. Many elderly people have more than one health problem and may need more than one type of health care provider. Estimates indicate that some 15-20%, between 3 and 5 million, of our nation's more than 25 million older persons have significant mental health problems. Moreover, in 1982 those persons over age 65 accounted for just over 10% of the U.S. population, but 17% of deaths by suicide. Despite many mental health needs, the elderly population are denied adequate treatment because of discriminatory "caps" imposed on psychiatric care under Medicare.

It is also critical to point out that older Americans are not the only persons eligible for Medicare. There are hundreds of thousands of young Americans who are also eligible for Medicare through the Social Security Disability Insurance Program. Many of these persons suffer from serious mental illness, which makes it very difficult for them to work, and therefore, they become eligible to receive SSDI. It is these most vulnerable Medicare beneficiaries, who will need care periodically throughout their entire life, that are most hurt by the severe restrictions in the inpatient and outpatient psychiatric benefits under Medicare. The costs associated with the care of the chronically mentally ill can easily reach catastrophic expenditures, especially when work is not possible. These people can also be expected to live a normal lifespan.

Cost-effectivenss of Mental Health Care

Many studies have documented the offset effect -- a reduction in health care utilization when mental health services are provided. For example, one recent NIMH study of Aetna Life

Insurance Company's claims from 1980-83 for enrollees in the Federal Employee Health Benefits Program compared overall health care service use by those families using mental health care services versus those families not using mental health services. Prior to the initiation of mental health treatment, use of overall health services rose gradually for three years with a sharp increase during the six months immediately preceding mental health treatment. Once mental health treatment was initiated, overall health use fell, and the greatest decrease in health utilization occurred for persons over age 65. Overall, general health use cost $493 per month for the first six months just prior to intitiating mental health treatment and $137 per month three years after treatment. The additional cost of mental health treatment was $13.96 per individual covered by the plan. The authors of the Aetna study caution that interpretation of other data over short periods of time may mask the dramatic nature of changes in health care service utilization after mental health treatment commences.

Limitations in Coverage of Psychiatric Care

Under the current Medicare program outpatient benefits are restricted to $250 annually after coinsurance and deductibles. Inpatient care in a psychiatric hospital is limited to 190 days per a beneficiary's lifetime. Both of these provisions have not been changed since the inception of the Medicare program in

1965. These discriminatory benefits do not only have a devastating impact on Medicare beneficiaries who need mental health services, but many private insurers have modeled their coverage after the Medicare program's psychiatric benefit structure. For example, a survey conducted by APA of 300 insurance plans published in 1983 indicated that although all plans had some level of coverage (inpatient and/or outpatient) for mental illness, only 6% of the plans had outpatient and inpatient coverage for mental illness comparable to that for physical illness. For these reasons, both Medicare beneficiaries and those persons with private insurance are greatly at risk of having large out-of-pocket expenses if they or a family member suffers from serious mental illness.

As pointed out earlier, the advances in the diagnosis and treatment of mental illness have been substantial since the beginning of Medicare in 1965, however, the restrictions in the psychiatric benefits under Medicare have not been revised. Medicare, for instance, was passed at a time when most patients were hospitalized in state mental hospitals -- far from their homes and without hope of discharge. Now there are many alternatives including private psychiatric hospitals and multiple outpatient psychiatric medically necessary treatments. The continuation of the 190 day lifetime limit prevents Medicare beneficiaries from receiving the needed care in the most appropriate setting. In addition, the outpatient benefit of $250 annually was put in place in 1965 and has not been increased. The benefit is presently worth $60 in constant dollars. Inadequate coverage for the full continuum of services needed by serious mentally ill persons creates incentives for inappropriate care which in the long term proves more costly to the Medicare program and society at large. For example, coverage for partial hospitalization -- an intensive, rehabilitation/habilitation outpatient service -- may prevent more costly inpatient care or could shorten a patient's length of stay in a hospital. It is evident that the psychiatric benefits under Medicare have not kept pace with the advancements in the delivery of psychiatric care. The time has come to allow the mentally ill who are Medicare beneficiaries the same coverage as those persons suffering from physical illnesses.

Recommendations

As the Finance Committee deliberates on catastrophic health insurance, we urge the committee to carefully consider the mental health needs of the Medicare beneficiaries. It is essential that funding for catastrophic care avoid the discrimination and stigma attached to mental illness. There must be non-discrimination within catastrophic health insurance for the treatment of mental and physical illness. It is critical that expenditures for mental health services are included in the "trigger" for catastrophic costs, and that the inpatient and outpatient limitations under Medicare be eliminated. It is very clear to the families who have dear ones who suffer from mental illness that mental illness is truly a catastrophic disease.

In closing, we believe that Senator Matsunaga's recently introduced bill, S. 718 co-sponored by Senators Rockefeller and Melcher, is a first step in the direction of easing the burden for the elderly and chronically mentally ill. However, we hope that all discriminatory provisions regarding psychiatric coverage under Medicare will be eliminated as part of a catastrophic health insurance proposal.

Mr Chairman, NAMI, APA, and NAPPH thank you for giving us this opportunity to appear before the Committee today and we look forward to working with the committee as you fashion a catastrophic health insurance plan for our Medicare beneficiaries.

STATEMENT BY

SENATOR JOHN H. CHAFEE

Mr. Chairman, as the debate on catastrophic health care progresses, I believe we must develop a guiding definition of a catastrophic illness expense. In my opinion, any health related crisis which has the potential of forcing an individual or family into or near poverty is catastrophic.

If we use this definition, it quickly becomes clear that a health care crisis is not limited to hospital care nor is it limited to those over 65 years old.

While it is true that between three and four percent of Medicare beneficiaries face out-of-pocket expenses of over $2,000 each year, more striking is the fact that five percent of all elderly individuals are in nursing homes at any one in time and the lifetime risk of entering a nursing home is about twenty percent. The average cost of one year in a nursing home is approximately $22,000.

For most of the elderly, the risk of needing long term care and entering a nursing home is their most paralyzing fear. They have good reason to be concerned. One-half of all payments to nursing homes are out-of-pocket expenditures by the elderly and almost all the rest are paid by the Medicaid program. Approximately one-half of all Medicaid recipients in nursing homes were not initially poor, but spent their income and resources on long term care before becoming eligible for Medicaid.

No elderly individual or couple should be forced into poverty before assistance will be provided for long term care for a chronic illness or debilitating condition like Alzheimer's disease.

There has also been a great deal of discussion about the availability of medigap insurance to cover acute care expenses of the elderly. While this is a viable option for individuals who can afford to pay the premium for such insurance, for a low income elderly individual, medigap insurance is not an option.

The need for protection from catastrophic illness is not limited to the elderly. Those under sixty-five are also at risk, and the needs of younger families and children with chronic illnesses or disabilities must be addressed.

More than one third of those without any health care insurance live in families with incomes below the poverty level, another one third live in families with incomes between 100 and 200 percent of the poverty level.

There are other individuals who, even if they could afford to purchase insurance, are without access to private health care insurance. These are people who have been denied private health insurance -- for example an individual with what is known as a pre-existing condition.

Finally, there are individuals with chronic illnesses who exhaust their private health care insurance and have no where to go but into poverty to qualify for medicaid benefits. For families with a chronically ill child this is a real threat.

So, Mr. Chairman, if we are truly to address the issue of catastrophic illness expenses in this Committee, we must begin with a broad view of the problem and we must keep an open mind to find solutions.

I am not without suggestions. I would like to briefly outline a number of proposals I am working on.

I have developed a proposal I call MedAmerica. This proposal will address the health care needs of those under the age of 65 as well as low-income elderly individuals. This bill would build on the existing Medicaid program in four ways:

First, it would sever the tie between Medicaid and cash benefit programs -- such as AFDC and SSI. As a result, states would have the option of providing Medicaid benefits to anyone whose income is below the federal poverty level, regardless of whether or not they qualify for cash welfare programs.

Second, states would have the option to allow individuals -- the so-called "working poor" -- whose incomes are at or near the federal poverty level to purchase health insurance through Medicaid for an imcome-adjusted premium, not to exceed 5% of the individual or family's adjusted gross income

Finally, states would have the option to allow persons with family incomes and resources in excess of 200% of the federal poverty level to purchase medicaid benefits if they have been excluded from private health insurance coverage because of a medical impairment or disability or if they have exhausted one or more benefits under their private insurance plans.

At a minimum, a state which elects this option would have to cover the following items and services: inpatient hospital care; outpatient hospital care; laboratory and x-ray services; EPSDT and family planning services; physicians' services; dental services; prescribed drugs; dentures; prosthetic devices; eyeglasses; and other diagnostic, screening, preventive and rehabilitative services. These benefits would also be required to have a catastrophic component designed to address the needs of those who have exhausted their private health care insurance.

Additionally, at its option a state may include in this plan all other services allowed under federal law, including home and community-based care services, but excluding services of long-term care institutions including skilled nursing facilities, intermediate care facilities, and intermediate care facilities for the retarded.

I have requested information on the cost of this approach from the Congressional Budget Office and will introduce this legislation when the cost estimate is available.

This proposal is clearly an ambitious one and it may not pass in total this year; however, I believe that there are components of this bill which address problems we will want to solve this year and I think it is important for us to explore this approach.

At the beginning of my statement I discussed the health care concerns of the elderly. To address these concerns, I believe we must take three steps. First, we must ensure that the out-of-pocket expenses the elderly are responsible for under the Medicare program are controlled. I have cosponsored legislation to do this, S. 754, which was introduced early this week. However, I wish to make it clear that this legislation is simply a very small first step.

The legislation would place a cap on out-of-pocket expenses that the elderly are responsible for under the Medicare program. Once a beneficiary reaches that cap amount, he or she will no longer be responsible for additional expenditures. In addition, the legislation will limit the number of first day deductibles in the hospital to one every calendar year and will eliminate copayments for hospital and skilled nursing facility services.

These changes are needed. However, they fall short of providing comprehensive protection for individuals facing catastrophic health care expenses. I have co-sponsored this legislation because it is an important starting point for the debate on catastrophic health care expenses. I am willing to work with others to expand the benefits and to consider methods other than a premium to finance them.

The second step we must take is to provide a comprehensive post-hospital care benefit. For the most part, I think that discharging patients from the hospital sooner is a benefit of the prospective payment system; however, we have not done anything to provide the support those patients need while they are recovering. I believe we can address this problem in a fiscally responsible way by developing a post-hospital benefit that covers a broad range of home and community based services and I am working on a proposal to do so.

The last and most critical step we must take is to develop a comprehensive and responsible long term care system.

We have our work cut out for us in the Senate this year if we are to solve even a fraction of the catastrophic illness problem. The issues are broad and complicated, and real solutions may be expensive. I look forward to working with my colleagues on this Committee to resolve these troubling problems.

STATEMENT OF SHERVERT FRAZIER, M.D., MEDICAL DIRECTOR, MCLEAN HOSPITAL, BELMONT, MA

Dr. FRAZIER. Mr. Chairman, since this legislation was passed in 1965, there has been a revolution in psychiatric care, and that is based on psychiatric research. The research obviously has yielded new drugs, new treatments, new rehabilitation mechanisms. Up to 85 percent of the people with major disorders of depression or mania are now treatable and successfully treated. We also have recently, in today's paper, the finding of a genetic marker in manic depressive illness on the X chromosone in five Israeli families. In the last couple of weeks we have had another finding on the chromosone 11 for manic depressive illness. It is pretty clear also with Altzheimer's and chromozone 21. We are finding the marker which allows for the precise diagnosis of these illnesses. With precise diagnosis, we can keep from making people who have formerly been called demented or senile, keep them from being called that and find what the depression is, treat the depression effectively, separate out those who need rehabilitation in an effective way.

We have new drugs for obsessive compulsive disorder, successful drugs for panic disorder, for phobia. We obviously are looking at biological and genetic markers.

The process is an ever rapidly increasing one. The human genome is in the process of being mapped.

The problem we have is that the mentally ill, having a real medical illness, are beset by the mythology of the past which essentially says pull yourself up by your boot straps and get over your illness. You cannot get over your genetic illness. It is a real medical illness. The mentally ill need to be treated equally as the physically ill are treated. We need to remove this injustice which is unfair to the mentally ill. They have a serious illness, a long-term illness and a recurring illness. And many of them can be effectively treated.

I hope you will really remember that the mentally ill need equal treatment for their medical illness.

Senator DASCHLE. Thank you very much, Dr. Frazier. Thank all of you. Senator Matsunaga.

Senator MATSUNAGA. Thank you, Mr. Chairman. It is good to be called "Mr. Chairman," being the most junior member of the committee. [Laughter.]

My question is for either Miss Miller or Dr. Frazier. In recent years, as you both have pointed out, landmark research discoveries about the causes of mental illness have been made. I wonder what impact these discoveries, such as the identification of defective genes in depression and Alzheimer's disease, will have on the treatment of elderly individuals with mental illness?

Dr. FRAZIER. Thank you, Senator.

Depression is being separated out from persons who have Alzheimer's. There is a condition which essentially mimics Alzheimer's, which is really due to depression. And getting the precise diagnosis so that those persons are not just said to be long-term ill with Alzheimer's when, in fact, they have a treatable depression which will respond to effective treatment in a few week's time.

It is pretty clear also that as we make progress we are able to get biological markers which will be kind of like laboratory tests which will help us to make the diagnosis, and will therefore speed up the availability of immediate intervention and good treatment.

More than half the people who have depression in this country do not have it recognized and don't have it diagnosed, which is to say that there is a serious lack of available resources to look at making the diagnosis and doing it in a precise way.

The research has changed the awareness of the practitioners as well as the people. People who hear about it now get their relatives in to get the diagnosis and get the treatment started.

Senator MATSUNAGA. Have you any projection as to how many of those who are ill and diagnosed as having medical problems would be determined to be mentally ill if proper training, and proper medical facilities, such as psychiatric facilities were available?

Dr. FRAZIER. Yes, sir. The epidemiological study from the National Institute of Mental Health, which was published in November 1984, showed that 19.6 percent of Americans have a diagnosable mental disorder in a certain period in their lives. That is to say that the illness can be diagnosed.

Now about 7 or 8 percent of those are phobias and panic disorder. Another 7 or 8 percent are substance abuse disorders. If you get right down to the major mental illnesses, we are talking about 8 percent of the population. Five to 6 percent of the people in the country have effective disorders at one time or another in their lives, and 1 percent of the population—about 3 million people—have schizophrenia. And schizophrenia, as you know, is a serious progressive and often deteriorating disorder.

So it is a vast number of people. The training of professionals to make the diagnosis is improving greatly in two decades, and more and more people are being recognized as having the illness.

The other problem is that about, with the people with mental illness, about 30 to 40 percent of them have physical illness which goes along with the mental illness. And that means that many of them don't see primary mental health specialists but see primary practitioners, health care deliverers. They are increasingly recognizing the mental disorder which they see in their patients who have medical disorders of a physical type.

Senator MATSUNAGA. Would you say that the Administration's bill on catastrophic insurance would not provide for the care of this vast sector of our population.

Dr. FRAZIER. That is true. It discriminates against those with mental illness. It retains the injustice that mentally ill persons have suffered in the present law. It also retains the arbitrary limits which essentially is $250.00 for an outpatient, which Miss Miller just talked about. It is just not enough. It doesn't even scratch the surface. It also maintains a 190-day lifetime hospitalization in a psychiatric hospital for inpatient care. This is limited coverage. It is not the kind of coverage—it is saying fiscal policy dictates the kind of care the individual has to receive, not having the medical professional decide what the patient needs and how it ought to be delivered. That includes inpatient care for the acute phase. To be sure, it includes outpatient care with a rehabilitation component. It includes the outpatient care of a partial hospitalization type. And it is much cheaper, by the way.

The present law essentially says that if you go to a psychiatric hospital and you are above the 190-day limit, you are moved to a general hospital. And a general hospital gives a similar kind of treatment that costs two to three times as much for the delivery of the care to mentally ill patients.

Senator **Matsunaga**. If I may proceed.

Senator **Daschle**. By all means.

Senator **Matsunaga**. Miss Miller points out in her written statement that the bill which I have introduced, S. 718, with the cosponsorship of Senators Rockefeller and Melcher, is a first step in the direction of easing the burden for the elderly and chronically mentally ill. Do you agree with her?

Dr. **Frazier**. I certainly agree. It is a fine bill. And as you say, it is a good first step. It really eases the burden and begins to change the—relieves the injustice. It makes it fair.

Senator **Matsunaga**. Thank you very much.

Miss Nash, would you go to the extent of saying that unless we provide for long-term care patients we would not be accomplishing very much with the catastrophic bill that we have before us?

Ms. **Nash**. Yes.

Senator **Matsunaga**. You would.

Ms. **Nash**. That is what I think. That is what we think actually. And what I would like to emphasize is it is not long-term care so much in a nursing home as it is at home.

Now that you have called on me, I could add another piece of this that you might be wondering about because we represent cancer patients, who make up the majority of people who are treated in Hospices, which Medicare coverage is given to.

You might wonder, what about Hospice in relation to this? Number one, there aren't Hospices in all areas. So you can forget about that. But also so many people do not want to acknowledge that they are going to die. They might when they are 40 say, well, when I am going to die I will be ready to die, and so on. But when push comes to shove, that isn't what happens. And I have seen it too many times too close to home and, therefore, I feel I know.

Also, children don't want to say to their father or their mother, you have got to go to a Hospice. You have got to give in to this. It is a very tough decision to make. It is not that I am against the Hospice concept. I am not. But it is not for everybody.

Senator **Daschle**. We want to thank the panel immensely for their contribution to this discussion, for your insight and for the information that you have shared with us all. Thank you all. And the hearing is adjourned.

[Whereupon, at 12:34 p.m., the hearing was concluded.]

[By direction of the chairman the following communications were made a part of the hearing record:]

ASIM TODAY

STATEMENT

OF THE

AMERICAN SOCIETY OF INTERNAL MEDICINE

TO THE

SENATE FINANCE COMMITTEE

ON

CATASTROPHIC HEALTH INSURANCE

MARCH 19, 1987

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STATEMENT OF THE
AMERICAN SOCIETY OF INTERNAL MEDICINE
TO THE
SENATE FINANCE COMMITTEE
ON
CATASTROPHIC HEALTH INSURANCE

ASIM is a federation of state component societies of internal medicine with over 20,000 members who, by training and practice standards, are recognized as specialists in internal medicine and its subspecialties. The vast majority are in direct patient care. Due to the nature of the specialty, internists have a broader perspective on our health care delivery system than other groups of physicians. Most deliver all levels of care -- in the office, in the hospital, and in extended care facilities. It is important to share this broad perspective as it relates to the proposals before this committee.

According to a recent study by the National Center for Health Services Research, nearly 16 million American families, or about one family in five, incur catastrophic out-of-pocket medical costs each year. Catastrophic costs were defined in the study as those out-of-pocket expenses that: 1) are not covered by private or public health insurance or by Medicaid or other government programs; and 2) exceed 5 percent of a family's gross income. The study revealed that families suffering catastrophic costs were of two types: 1) families that had good insurance coverage but incurred large costs beyond that coverage and 2) low-income families with inadequate health care coverage whose out-of-pocket expenses were small but burdensome in relation to their income. ASIM believes that no American should suffer financial disaster because of the cost of health care and supports the availability of coverage to provide protection to all Americans against financially catastrophic medical problems. As early as 1974, ASIM publicly supported the concept of catastrophic health insurance. Later, the Society testified in support of the "Catastrophic Health Insurance and Medical Assistance Reform Act" before the Senate Finance Committee in March 1979.

The Administration Proposal

The Society is encouraged by the considerable interest of the Administration and Congress in formulating a national health policy to address the problem of affordable catastrophic insurance coverage for older Americans. Although the Society is supportive of the Administration's proposal (S. 592/H.R. 1245), based on earlier recommendations of Secretary Bowen to expand Medicare to cover the cost of catastrophic illness through a monthly Part B premium, ASIM has reservations about financing the benefit solely through higher premiums applied equally to all beneficiaries enrolled in Medicare Part B. This aspect of the Administration plan will adversely affect low income beneficiaries and require Medicare beneficiaries to bear the full cost of the catastrophic benefit. ASIM encourages members of this committee to consider modifications to minimize the impact on low income beneficiaries through such mechanisms as: 1) increasing Part B premiums for higher income beneficiaries only; 2) increasing hospital coinsurance for higher income beneficiaries only; 3) varying the catastrophic cap by income; and 4) as a last resort if other financing mechanisms are insufficient or not politically acceptable, taxing the actuarial value of Part A and Part B benefits, as proposed by Representatives Stark and Gradison.

In 1984, ASIM addressed the issue of catastrophic coverage for the elderly as part of a study to identify reasonable and practical approaches to restoring the solvency of the

Medicare program. In the report, ASIM addresses a number of the recommendations discussed above, including the establishment of an income-related cap on beneficiaries' out-of-pocket costs for covered services (Medicare's Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) combined) and increasing hospital coinsurance and/or premiums for those beneficiaries who can afford to contribute more to the cost of their care. An income-related cap on out-of-pocket expenditures would result in considerably more protection for catastrophic illnesses than would be available to beneficiaries through the Administration plan (which sets a cap on out-of-pocket expenses for everyone at $2,000) since the cap would be set at a level that reflects a reasonable definition of "catastrophically" expensive illness, based on ability of each beneficiary to contribute out-of-pocket for necessary care.

ASIM's 1984 solvency paper cites several ways that the Congressional Budget Office (CBO) believes that premiums could be varied by income (CBO, Changing the Structure of Medicare Benefits: Issues and Options, March 1983). Although the CBO numbers may need to be updated, the report provides two feasible examples of how this proposal may be implemented. CBO proposed one option that would require single persons with incomes above $25,000 and couples with incomes overs $32,000 to pay 30 percent of SMI costs. (Currently the proportion of the Part B costs financed by enrollees is set at 25 percent of program costs.) CBO projected additional revenue of $1.7 billion over a 5 year period. A second option suggested by CBO would require single persons with incomes above $25,000 and couples with incomes over $32,000 to pay 35 percent of SMI costs. The Medicare program would accrue $2.7 billion in additional revenue over a five year period under the second option.

To further shield low income beneficiaries from excessive out-of-pocket expenditures for medical care, ASIM believes additional funding mechanisms should be considered by the committee that spread the responsibility for financing the new benefit to groups outside the beneficiary community. Those modifications could include:

- Increasing the excise tax on alcohol and tobacco and dedicating at least a portion of the revenue to Medicare. Doubling the cigarette excise tax from 16 cents to 32 cents per pack would produce $3.3 billion in new revenues in FY 88; and

- Imposing the Medicare payroll tax on currently exempt state and local government employees. This option would produce as much as $1.6 billion in revenues per year.

Developing Financial Protection For Long-Term Care Costs

The Society believes that the Bowen/Administration plan is a significant step forward, but that it still does not go far enough, since it is silent on the issue of catastrophic coverage for nursing home care, community-based services and chronic illnesses requiring long-term care. Although the Society believes the committee should consider ways to provide catastrophic protection for chronic and long-term care expenditures in addition to expenses related to long hospital stays, ASIM understands that developing appropriate ways to finance long-term care may entail considerable study. Therefore, ASIM can support a catastrophic proposal that includes coverage for acute care only, while recognizing the need for future consideration of ways to expand coverage for long-term care. The Society is currently studying the issue of long-term care and will be offering its own recommendations to the committee in the future.

Among Medicare beneficiaries, the most critical need for catastrophic protection is for expenses associated with long-term, chronic illness. Of those beneficiaries who pay more than $2,000 per year for medical care, 80 percent of the expenses incurred are for nursing home care. Medicare currently pays for only limited stays in nursing facilities (Medicare paid for less than 3 percent of expenditures for nursing home care in 1985). The principal source of government financing for long-term care is Medicaid, the federal-state health care program for the poor. But to qualify, elderly persons must first exhaust all resources.

The use of Medicaid to pay for the long-term needs of Medicare patients has put considerable pressure on funds available to support the non-Medicare population living near or below the poverty line. For those without insurance, any significant illness is generally catastrophic. Economic pressures, coupled with health care cost containment efforts and the lack in federal funds for health care programs has created an environment in which more persons have found themselves without either health insurance or coverage under existing state or federal medical assistance programs. For example, the percentage of the non-elderly population without health care increased from 14 percent in 1979 to 16.5 percent in 1983, according to the Employee Benefit Research Institute. During this time, however, there also was a decrease in the percentage of the population that was able to qualify for Medicaid. In 1975, 63 percent of low-income people were eligible for Medicaid, compared to 40 percent in 1983.

The lack of private long-term care insurance and adequate personal resources will continue to force individuals to risk financial devastation in the event of long-term care. Moreover, the number of uninsured and underinsured Americans continues to grow, with as many as 37 million persons being without adequate coverage. Consequently, discussions of the catastrophic care problem must not only focus on the acute care expenses of the elderly, but must extend to the long-term care costs and other catastrophic expenses incurred by all Americans. ASIM supports the concept that employers make available a minimum benefits package to all employees. The Society will be providing the committee in the future with recommendations on how this can be accomplished, on the types of benefits to be included in the minimum benefits package offered by employers, and on the advisibility and feasibility of expanding Medicare's proposed catastrophic benefit to include benefits for currently non-covered services, such as prescription drugs.

ASIM also believes that adequate health insurance for a significant portion of the uninsured and underinsured could be provided through the establishment in each state of a risk pooling program in which all health care underwriters in a state participate. The tax code should be amended to ensure the participation of self-insured groups, by requiring such participation as a condition for deducting the costs of health insurance coverage as a business expense. The risk pool would be open to both the medically uninsurable and standard risks who lack access to group coverage.

Conclusion

In conclusion, ASIM welcomes the opportunity to work with the committee in developing a proposal to protect the elderly and others in the future from catastrophic health care costs. The Society also requests that the committee carefully review ASIM's report on restoring the solvency of the Medicare program, which is appended to this testimony, and include it in the official record of the hearings on the subject. Congress should specifically consider modifying HR 1245 to vary beneficiary out-of-pocket contributions and the catastrophic cap by income and to obtain additional revenue from sources other than beneficiaries themselves.

ASIM expects to be providing the committee with additional recommendations in the future on such issues as:

- financing long-term care through the private and/or public sector;
- implementing public and private sector initiatives to reduce the number of uninsured (e.g. by providing incentives for employers to offer a minimum benefit package for all employees);
- the advisability and feasibility of expanding the benefits offered through Medicare's proposed catastrophic plan to include currently non-covered services such as prescription drugs and an expanded home health care benefit; and
- the types of benefits that should be included in minimum benefits packages offered by employers.

AGE AND YOUTH IN ACTION
GRAY PANTHERS
PROJECT FUND

Catastrophic Health Protection

Statement by
Frances J. Humphreys
Gray Panthers

Submitted to the Senate Finance Committee
Chairman Lloyd Bentsen
March 30, 1987

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Mr. Chairman, I am Frances Humphreys, Director of the Washington Office of the National Gray Panthers. The Gray Panthers is an intergenerational organization of 74,000 members working on issues involving social and economic justice. Much of our work is concentrated on health issues. We believe that adequate health care is a right, not a privilege, and our ultimate goal is a national health service. Our short-term goal is to monitor and improve the present health system wherever we can. In carrying out this work we have confronted the inadequacies and inequities of this system and we are glad to have this opportunity to share with you our concerns and state our position on catastrophic health care.

We commend you for your attention to the issue of catastrophic health protection. However, we would like to expand the dialogue. The principal intent of such protection seeks to prevent depletion of a person's financial resources when faced with a major and devastating illness. This term, catastrophic protection, was clearly coined for individuals who possess a comparatively sound economic base and therefore the focus on that kind of protection. We would all agree this concern is legitimate for that segment of the population. But there is a larger population and other catastrophic occurrences that concern Gray Panthers. I would like to present examples of that concern.

A baby born dead because his mother did not receive adequate pre-natal health care is also a catastrophe. Note that it does not meet the limited stated viewpoint of catastrophic illness. We believe it should. According to the American Medical News, July 19, 1985, twenty-five percent of all American women in the peak child-bearing age 18 to 24 are unable to obtain public or private health insurance. As a result it is unlikely that these women will receive adequate pre-natal or childbirth care. Medicaid expansion legislation contained in the Omnibus Budget Reconciliation Amendments (OBRA '86) will extend benefits, at states' option, to a portion of this population and that's a step in the right direction. But it doesn't go far enough. There will still be pregnant women outside the health care system. The Children's Defense Fund reports that forty percent of all hospital care provided by public hospitals for uninsured patients involves obstetrical cases. Uninsured newborns represent some of the most expensive care public hospitals provide. Because of the expense involved, pressure is created to reduce the amount of care given even though it is desperately needed.

At the other end of the age spectrum, the elderly, many of them on very limited incomes, are finding it increasingly difficult to afford the inflated costs of health care. This problem has been compounded by recent policies that save the government money but increase the cost to the individual. Again, this is not a problem of catastrophic illness as presently defined, however, it means that the three and a half million elderly Americans living at or below the poverty line may go without needed health care services including dental care, eye care, prescription drugs and even seeing a doctor when they are sick. This kind of neglect can lead to illnesses and conditions that result in health catastrophes. Medicare covers less than half of the medical costs of the elderly. Many in this group can not afford private supplemental insurance to fill the gaps. Neither can they afford higher Medicare premiums. Protection in this area is essential, but the cost to the individual must be affordable.

A third problem is the portion of long-term care that does not qualify for most catastrophic plans, including nursing home and home health care services. Many illnesses, chronic and disabling, that are costly to the individuals and families involved are not classified as catastrophic, such as rheumatoid arthritis, osteoporosis, Alzheimers Disease and many others. Current catastrophic protection proposals that apply only to illnesses that require hospitalization would benefit no more than an estimated one percent of all Medicare patients.

In summary Gray Panthers feel that the intent of catastrophic illness coverage is too limited. A focus on economic protection for the cost of hospitalization is not enough. I would like to reemphasize the fact that many segments of the population do not have access to the health care they need. Gray Panthers recommend that the Medicare and Medicaid programs be expanded immediately to provide health care services in areas of greatest need. As a start the provisions in OBRA '86 to expand Medicaid coverage to pregnant women, infants, the elderly and the disabled living below the poverty line should be made mandatory. Long term care, both nursing home and home health services should be fully covered under Medicare along with the health care needs such as prescription drugs, that are now paid out-of-pocket.

What is a health care catastrophe, Mr. Chairman? It's when someone who needs proper health care is unable to get it. Two years ago Maggie Kuhn, Gray Panthers National Convener, led a study team to Canada for a first hand, in-depth look at their health care system. We interviewed health care professionals, surveyed health care facilities and talked to private citizens. What we learned was most instructive. Health care in Canada, although provided through the private sector, is coherently arranged and well-regulated. Most importantly, it provides health care to all. Our hosts told us that Canada made a commitment to provide health care to each of their citizens and they have met that commitment. The United States is the only industrialized nation with the exception of South Africa, that does not provide comprehensive national health care. We must do better. Gray Panthers call upon Congress to work toward a plan that will provide community based, quality health care to all, the only effective response to our catastrophic health care problems.

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